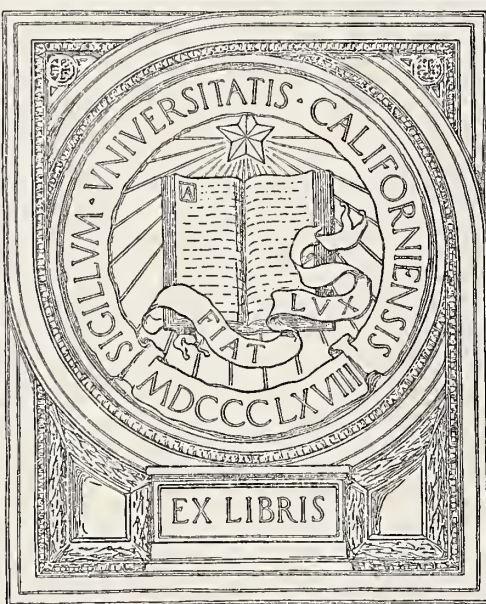
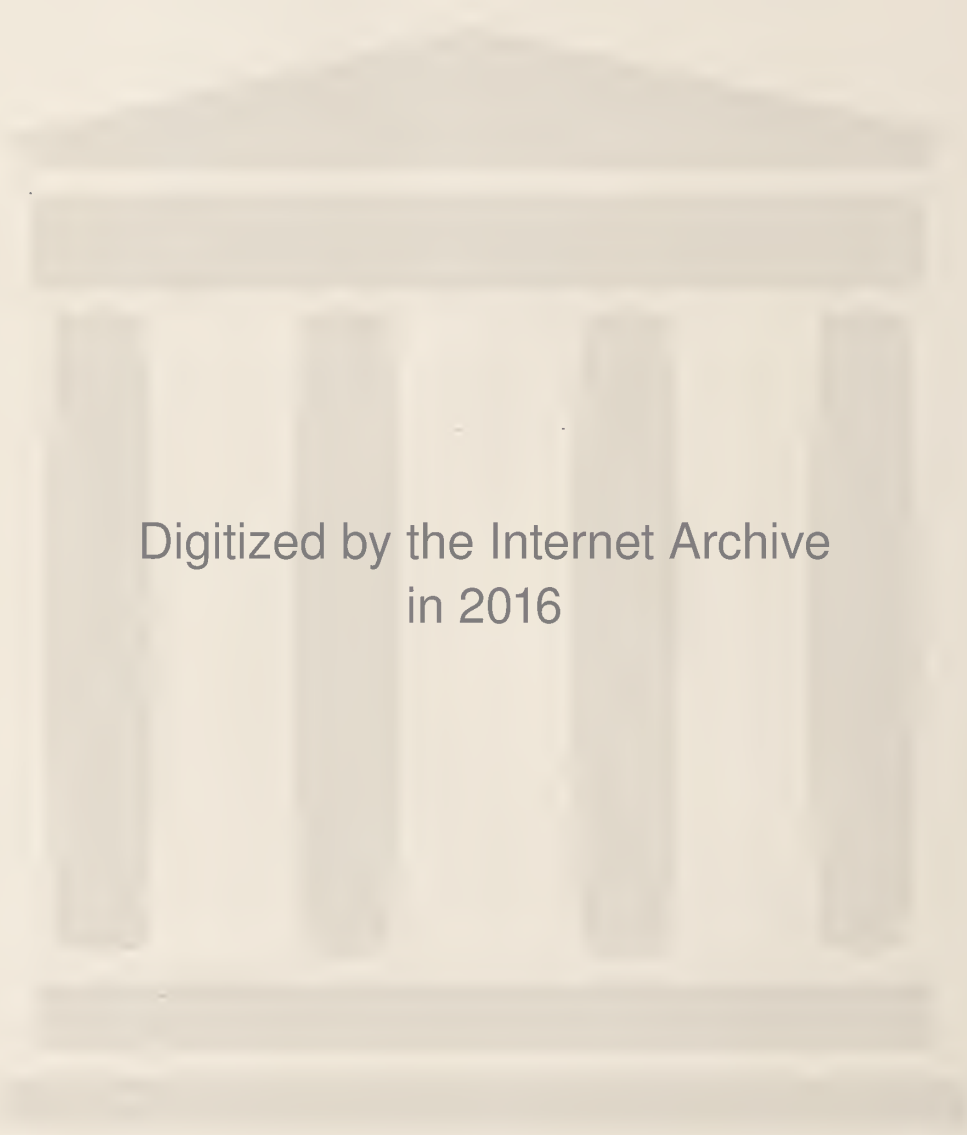


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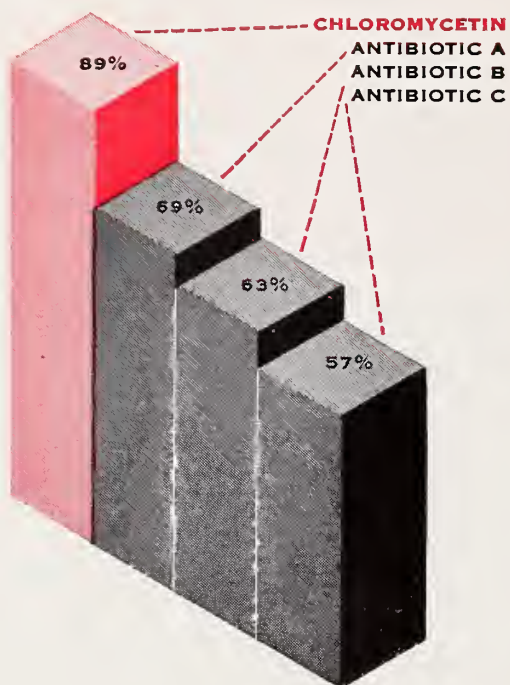
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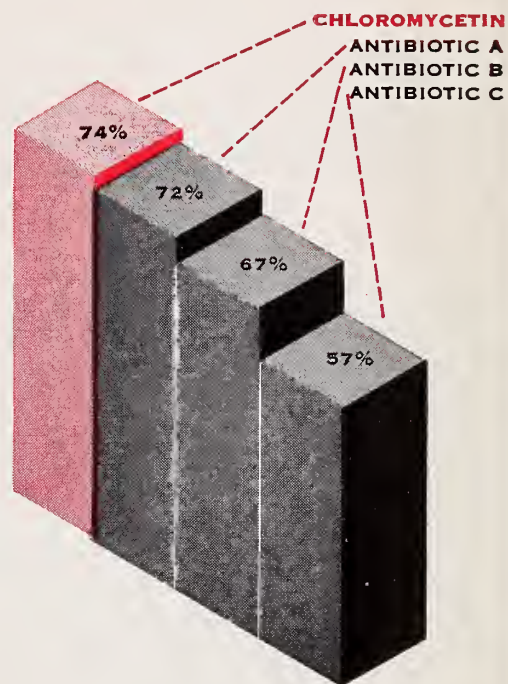


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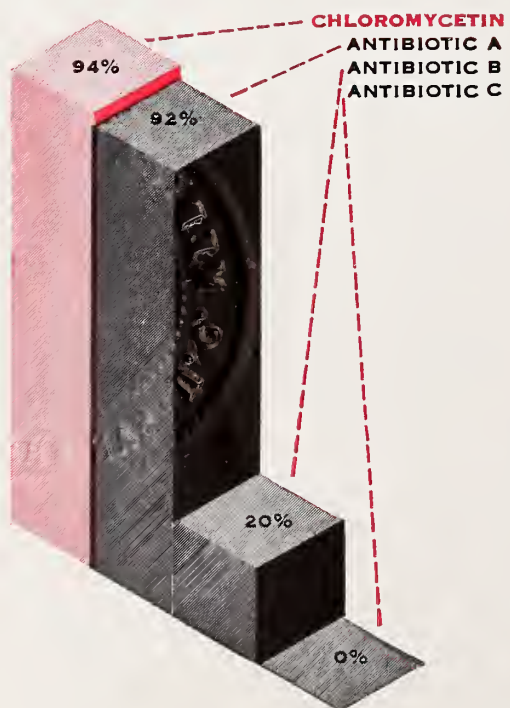
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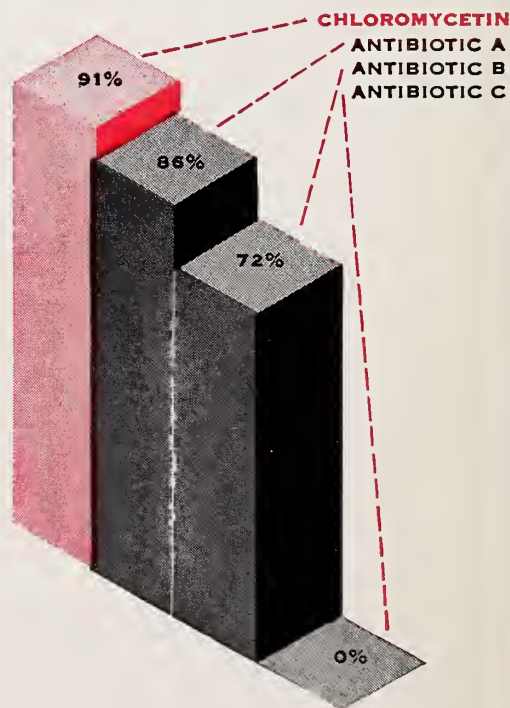
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Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

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COVER

One of the major projects of the Medical Association this year is to promote safety on the highways of Georgia. We open this new year with a reminder to all our readers to drive safely, and with the MAG's safety sticker, attached to the bumper of your car remind others to do the same. (See also page 21.)

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Dependents' Medical Care Act

On December 14, 1956, every doctor of medicine in Georgia received a mailing from the Medical Association of Georgia in fulfillment of the Association's contractual responsibilities in serving as contractor for the Government in implementing the Dependent's Medical Care Act, Public Law 569, 84th Congress. The mailing included (1) a one-page directive giving a brief explanation of this act; (2) specimens of Dependents' Medical Care Act identification cards acceptable for identification by physicians as evidence of the dependents' eligibility; (3) Medical and Surgical Procedures pamphlet listing uniform nomenclature and standardized code system with an Appendix I listing maximum fees allowable for the more common procedures; and (4) claim forms (DA Form 1863) to be filled out in duplicate and forwarded in duplicate to the Association for remittance.

Again the Association wishes to call your attention to a brief resume of the provisions of this act as it applies to physicians and surgeons in the State of Georgia.

MEDICARE PROVISIONS

(1) December 7, 1956, is the effective date of this program and any medical treatment rendered prior to that date does not come under this Act.

(2) Military dependents seeking medical care must submit to private physicians identification cards as evidence of eligibility. "Dependents eligible for Civilian Medical Care means the lawful wife or the dependent lawful husband (spouses) and children who are dependents of members of the uniformed services."

(3) Under the provisions of this Act medical and surgical *in-hospital* treatment by physicians is authorized and *outpatient* care is not authorized, except that (a) services required of a physician or surgeon prior to and following hospitalization for a bodily injury or surgical operation; (b) obstetrical and maternity services; and (c) certain emergency conditions, are authorized in hospital, office or home.

(4) Physicians or surgeons are requested to consult the "Medical and Surgical Procedures" which lists a standardized code system and uniform nomenclature to be used by physicians in reporting claims to the Association. Physicians or surgeons are also requested to charge their *usual and normal fees* within the maximum "ceilings" in the Appendix I—113056 as negotiated by the Association and the Government. Physicians participating in this program will receive payment in full for their usual charge or the amount set in the schedule of maximum fees (Appendix I—113056), whichever is less. Such fee is to be considered *payment in full*, and the physician will make no additional charge to the patient, *except* the only charge for which the patient is liable is (a) in-hospital care—approximately the first \$25.00 payable to the hospital; (b) outpatient care as authorized—the first \$15.00 of such physician's fees plus the cost of diagnostic tests in excess of \$75.00 payable to the physician; (3) diagnostic tests—in

excess of \$75.00 prior to hospitalization in excess of \$50.00 following hospitalization when performed by or authorized by the attending physician.

(5) For receipt of payment for medical or surgical services rendered under the provisions of this Act each physician is requested to fill out in *duplicate* DA Form 1863 and send this form in *duplicate* to the Medical Association of Georgia.

(6) Medical care *not authorized* under the provisions of this Act: (a) Chronic Diseases; (b) Nervous and Mental Disorders; (c) Elective Medical and Surgical Treatment; (d) Domiciliary Care; (e) Treatments or Procedures Normally Considered to be Outpatient Care, with certain exceptions noted above; (f) Ambulance Service.

(7) Dental care which is a necessary adjunct to medical or surgical treatment rendered *in a hospital* to a dependent *who is a hospital inpatient* and concurred in by the attending physician is authorized. Such dental care *shall not* include removable or fixed prosthodontic restorations.

ASSOCIATION RESPONSIBILITY

THE MEDICAL ASSOCIATION OF GEORGIA, as Contractor for the purpose of implementing the Dependents' Medical Care Act, P. L. 569, in the State of Georgia, shall perform certain services *directly concerning physicians*. These services are listed to acquaint physicians with the mechanics of this Act.

(1) The Association shall encourage physicians in the State of Georgia to provide authorized medical services for dependents of service personnel, authorized to receive such services under the provisions of the Dependents' Medical Care Act.

(2) The Association shall supply these physicians with the informational material in order that they may keep fully informed of all policies and procedures of the program.

(3) The Association shall supply these physicians

with "claim forms" (DA Form 1863) and receive from physicians these forms *in duplicate* as bills for services rendered by physicians furnishing services under the program.

(4) The Association shall supply these physicians with a Medical and Surgical Procedures pamphlet containing uniform nomenclature and a standardized code system to provide data for the physician's use in rendering bills (DA Form 1863), and supplemental data (Appendix I-113056) reflecting the *maximum fees* allowable for the most common medical and surgical procedures as authorized by the Government.

(5) The Association shall remit payments to these physicians on receipt of the physician's bill *in duplicate* (DA Form 1863) in accordance with the provisions of the Association's contractual obligations under this Act.

(6) The Association shall maintain appropriate medical committees or boards, as required, to review and consider all cases involving complaints, differences of professional opinion and misunderstandings; and advise and assist the Government on matters within the scope of the program. However, where such committee or board has no cognizance on the subject matter of a complaint or on the physician involved, then the matter will be forwarded to the Government Contracting Officer for consideration.

(7) The Association shall inform each physician as to identification of dependents eligible under the provisions of this Act and the physician should then

exercise reasonable care and precaution in accepting evidence of eligibility for subsequent entitlement to payment for services rendered.

(8) The Association has established through negotiation with the Government certain *maximum fees* allowable for any given procedure and payments made by the Association within this maximum allowance constitute *payment in full* for authorized services rendered. However, the Association shall obtain a report from a physician submitting a bill (DA Form 1863) for *procedures or services rendered which are not specifically indicated in the Medical and Surgical Procedures pamphlet, or in unusually involved cases*. Such report from the physician shall set forth in detail the basis for the fees. The appropriate medical committee or board of the Association shall determine the *tentative fee* to be paid on the basis of (i) reasonableness and (ii) comparability with fees for other procedures set forth in maximum fee schedule of allowances requiring similar degrees of skill, training and experience. The medical committee or board shall advise the Association which in turn will notify the Government Contracting Officer for final disposition.

(9) Should any physician in Georgia seek further information or clarification, please address all correspondence to Mr. Dougald Avera, Medicare Department, Medical Association of Georgia, 875 West Peachtree Street, N.E., Atlanta 9, Georgia, or telephone TR. 5-6303.

MILTON D. KRUEGER, *Executive Secretary*
Medical Association of Georgia

Mr. Avera Named Medicare Administrator

MR. DOUGALD M. AVERA joined the Association Headquarters Office Staff in the capacity of administrator of the Association's Medicare Department on December 10, 1956, to implement the Dependents' Medical Care Act.

Mr. Avera, formerly with the U. S. Gypsum Company, has a broad background of experience in accounting procedures, business administration and public relations activities. He is a 1949 graduate of the University of Georgia, Atlanta Division, with the degree of Bachelor of Commercial Science, and he received his Bachelor of Legal Law degree from Woodrow Wilson College of Law, Atlanta, in 1954. Mr. Avera, a native Georgian, was born in Quitman, and has lived in Atlanta since 1927.

Serving with the U. S. Navy during World War II and the Korean War, Mr. Avera attained the rank of chief petty officer in Naval Intelligence. His tours of duty included assignments in the District Intelli-

gence Office, Territory of Hawaii; Office of Naval Attache, U. S. Embassy, Moscow, USSR; and District Intelligence Office, Charleston, S. C.

In implementing the Medicare program in behalf of the Association, Mr. Avera will answer all queries from physicians and the public, disseminate Medicare directives and provisions to physicians, supply physicians with claim forms, receive and process claim forms from physicians, compile statistical data for the Government, make remittances to physicians under the provisions of the program, and handle accounting procedures inherent in the program.

All Georgia physicians are requested to write or phone Mr. Avera at any time for information in connection with the Dependents' Medical Care Act. Mr. Avera and the facilities of the Headquarters Office stand ready to serve you, and your cooperation will be appreciated.

Congenital Anomalies of the Arm and Hand

J. HIRAM KITE, M.D., and CHARLES R. W. REED, M.D., Atlanta, Ga.

THIS PAPER IS BASED on a study of 166 children with congenital anomalies of the arm and hand treated at the Scottish Rite Hospital for Crippled Children.

The deformities of the arm and hand have been classified under 28 headings. Some of the cases fall under several headings, but by placing each case under the major disability, we have the findings shown in Table 1.

Almost half of the deformities were due to webbing of the fingers. Syndactylism or lack of segmentation of the fingers occurred in 77 cases or 47 per cent. The next most common finding was a congenital absence of one or more fingers. This was true in 29 cases or 17 per cent. Twelve of these cases showed an absence of the thumb only. There were 13 cases of polydactylism. Brachydactylism occurred in 10 cases, and lobster claw in six cases.

Etiology

The etiology cannot be stated with any degree of exactness. The major deformities, like the loss of a part of the arm or the entire arm are probably due to an accident in the development of the limb and are not inherited. A minor deformity like syndactylism is a mutation and is inherited.

Inheritance occurred in only four of the 28 classifications. Syndactylism showed the highest inheritance. The parents or the grandparents in 21 per cent of these cases showed a similar deformity of the hands. Harris found a family history in five per cent, Barsky had the same, and Murphy had seven per cent. The higher percentage here may be explained by a more careful study of the families, and by the high occurrence in several families who live near the hospital. In one family the grandfather had bilateral syndactylism. Five of the 11

children had the same with slight variations. All five were operated upon when they were children. Three of these have married and all three have brought their babies for separation of fingers.

The second hereditary group is polydactylism, with 15 per cent. There were two instances of inheritance in the clinodactylia group and two in congenital absence of thumbs.

Hematomas and blebs have been used in the past to explain defects in the developing limb bud. Annular grooves and amniotic adhesions have also been used as an explanation of these defects, but there is little evidence to support any of these theories. Poor nutrition, toxic influences, X-ray, or German measles might affect the embryo one time,

TABLE 1
Classification of arm and hand anomalies found in this study.

Abrachius	1
Brachymelus	1
Hemimelus	3
Phocomelus	1
Cubitus varus	2
Clubhand	
a. Absence of radius	10
b. Absence of ulna	5
Radioulna synostosis	5
Ectrochiria	4
Acrocephalosyndactylia	2
Adduction of thumbs	2
Annular rings	5
Arachnodactylia	2
Brachydactylia	10
Brachymetacarpia	2
Clinodactylia	5
Ectrodactylia	29
Ectrosyndactylia	2
Lobster claw	6
Megalodactylia	3
Polydactylia	13
Symphalangism	1
Syndactylia	77

Other conditions:

Achondroplasia
Arthrogryposis multiplex congenita
Dyschondroplasia
Morquio's disease

Presented at the 106th Annual Session of the Medical Association of Georgia, May 13-16, 1956.

but it would not give the same deformity in subsequent pregnancies. When the deformity occurs in several children in one family, or is passed on to the next generation, we must think of it as imperfect developmental factors residing in the genes. At least in the four groups mentioned above, it seems that genetic factors are the principal cause of these deformities.

Syndactylism

Syndactylism occurs once in 1,000 to 1,500 births according to MacCollum. Bunnell says once in about 3,000 births. Syndactylism is probably due to an interference with the normal process of development at about the sixth week, when the digits are forming on the end of the limb bud. In some cases there are normal fingers which are webbed, and in others the fingers are smaller or show absence of the distal parts.

Syndactylism varies in the degree of the deformity. In some there is a loose web of skin extending only part of the way to the end of the fingers (Figure 1). In others the union extends to the end of the fingers, and in some the fingers are so tightly joined together that it is difficult to recognize the mass as two fingers. In some the nails have been fused, and in a few the distal phalanges are united by solid bony union. In an occasional case the entire shaft has fused and there is a common tendon for the two fingers, as well as blood and nerve supply. In a few rare cases the thumb and all of the fingers are fused into one mass, with one curved, irregular nail for the thumb and all the fingers (Figure 2).

Syndactylism varies as to the number of fingers involved. Barsky says the webbing is most frequently between the middle and ring fingers. In this series there is no great difference when only two fingers are fused. The webbing of two fingers is the most common finding, however, the index and middle fingers were fused 11 times, the middle and ring fingers 13 times, and the ring and little fingers 14 times. The thumb was fused to the index finger and others in two cases. With three fingers fused, the index, middle, and ring fingers were fused three times, and the last three fingers, five times. In seven cases all four fingers were fused together like a "mitten" (Figure 3).

Syndactylism is frequently associated with ectrodactylia or hypodactylia. In 38 cases the fingers were normal in appearance and in 39, the fingers were deformed.

Syndactylism is frequently associated with deformities in other parts of the body. In 48 cases there were other deformities. There were 11 with syndactylism of the toes. Ten had clubfeet. Four had annular grooves of the extremities. Four had a hare-lip and cleft palate. Three had deformities of the

face. Three had extra fingers, and three, extra toes. Three had an absence of one or more toes. Two had metatarsus varus, and two were mongolians. There was one with deformities of the ribs; one, of the hips; one, of the ulna; and one the loss of the other hand.

Authorities differ as to the time the fingers should be separated. Some wait until the child is three to eight years old, giving as their reasons that the operation is tedious to do in babies. If the fingers are the same length and do not checkrein each other, there is little harm in waiting. But, if the end of the fourth finger is joined to the end of the fifth finger at the same level, the fourth finger is checkreined so that the interphalangeal joints cannot move, and the finger develops a flexion deformity (Figure 4). It may require an osteotomy later to correct the deformity. Some of our best results have been obtained when the operation has been done between six and 12 months (Figure 5).

The operation of choice is to turn up a U-shaped flap from the dorsum of the fingers, leaving the pedicle proximal. The fingers are then separated and the flap drawn forward and sutured to the skin of the palm so as to line the commissure between the fingers. In separating the fingers, the incision should be zig-zagged on the palmar surface of the fingers. If this is not done, a keloid will form and the finger will become contracted. The denuded areas on each finger are covered with a whole thickness skin graft from the groin. Only one side of a finger can be operated upon at a time, so as not to injure the circulation to the finger. If the nails are fused, it is necessary to remove a part of the edge of the nail and a part of the nail matrix so as to prevent further growth along the edge. This favors better closure of the skin and prevents a sharp, unsightly edge to the nail on the side where it has been separated.

Polydactylism

Polydactylism was present in 13 cases, or eight per cent. In one patient there were seven fingers; in the others, six. There is usually a marginal duplication. When on the radial side, we find an extra thumb. This may be a well developed thumb or bifid at the distal end. On the ulna side we may have a finger which looks like the fifth finger. In one patient the extra finger was in the middle of the hand, the middle finger being shaped like the letter Y. Frequently there is an extra metacarpal for the extra finger, or there may be a Y-shaped distal end to the metacarpal. All variations occur.

Polydactylism is accompanied by a high percentage of deformities elsewhere. Nine of the 13 patients showed other deformities. Five had polydactylism on the feet. Two had syndactylism of the fingers.



Figure 1A

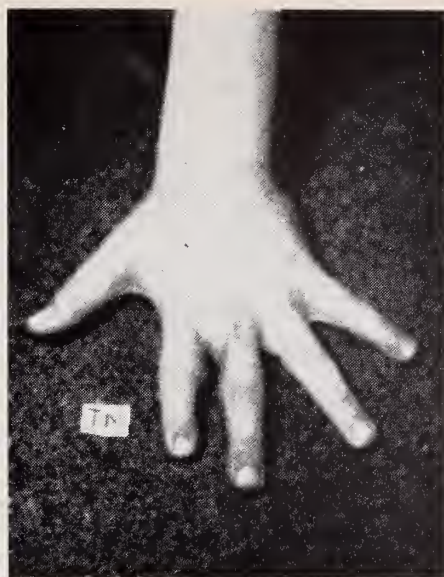


Figure 1B



Figure 2

Figure 1. a. The simplest form of syndactylism is a web of skin joining the index and middle fingers.

b. Result after the web has been divided, and a pedicle skin flap has been turned down from the dorsum to line the interdigital commissure.

Figure 2. Showing one of the most severe forms of syndactylism, in which the thumb and all the fingers are joined together. There is one common irregular nail for the thumb and all the fingers.



Figure 3A



Figure 3B

Figure 3. a. One of seven cases in which all the fingers were fused together like a "mitten."

b. Result after separation of the fingers.



Figure 4A

Figure 4. Thirteen-year-old girl with fusion of the fourth and fifth fingers. The short little finger checkreins the ring finger and prevents motion in the interphalangeal joints, so that the joints become stiff.



Figure 4B

b. After separation of the fingers, the ring finger is still deformed and stiff.

c. An osteotomy of the first phalanx of the ring finger was necessary to correct the deformity. Result is not as good as it



Figure 4C

would have been if the separation had been done earlier.



Figure 5

Figure 5. Result after separating the fourth and fifth fingers at six months. This permits early motion in the fingers, and the fingers develop more nearly to the normal size.

One had a harelip and cleft palate, one, a deformed ear, and one was mentally deficient.

Of two of these patients the father and grandfather had extra fingers. Seven of the cases were unilateral, and five, bilateral. Of the unilateral, there were three on the right and four on the left. There were 10 boys and three girls.

The extra finger is removed for cosmetic reasons, and also to improve function. Sometimes it is difficult to decide which finger to remove. This is true in double thumbs. Study should be given the hand, and at times it is well to wait until the patient is older before removing the extra finger.

Occasionally, the doctor delivering the baby will remove the extra finger or toe shortly after birth. This is usually an ill-advised procedure. In the cases we have seen there has been left an enlarged head to the metacarpal or metatarsal which is unsightly and in the case of the foot, makes the wearing of a shoe painful. It is better to leave the extra finger and have an adequate operation performed later. If the extra finger is only a rudimentary appendage attached by a small pedicle of skin this may be removed early, but it should be remembered that there is usually a fairly good sized artery in the pedicle.

Space does not permit the discussion of the other less frequent conditions. It is evident that we cannot

replace that which is absent. However, in the arm a prosthesis can be used to great advantage in many of the cases with loss of a part or almost all of the arm.

Summary

One hundred sixty-six patients with congenital anomalies of the arm and hand have been studied at the Scottish Rite Hospital for Crippled Children. These deformities have been divided into 28 groups. The largest group was syndactylism with 77 cases. Thirteen patients had extra fingers. These two groups are reported in detail. Operations are done to improve function and the cosmetic appearance. Prostheses were useful in the patients with congenital absence of a part of the arm.

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Surgical Treatment for Papillary Carcinoma of the Thyroid Gland

EDWARD S. JUDD, M.D., Rochester, Minn.

MUCH HAS BEEN SAID and written about papillary thyroid cancer in recent years. Earlier, it was a subject of considerable confusion because of the relatively benign characteristics of the growth. In fact, the almost undetectable primary tumor with an only too obvious metastatic lesion led some authorities to assume that the malignant lesion originated in lateral recesses of the neck and finally spread secondarily to the thyroid gland. The controversy was not helped any by adoption of such terms as "benign metastasizing goiter" and "lateral aberrant thyroid."

In relatively recent times, the behavior pattern has become quite clearly understood, so that most authorities are agreed on the histologic pattern, development, and ultimate spread of this interesting malignant tumor. It is only natural that aggressive treatment has now been proposed, for the application of the term "carcinoma" immediately calls to mind a rigid plan for eradication of the disease. My colleagues and I agree with those who insist on wide removal, but we have reason to believe that a mutilating type of sacrifice of a wide variety of normal structures may not be indicated in every case. We have been well satisfied with a plan adopted in our own institution and for the moment have found little reason to change it.

Characteristics of the Tumor

Histologically, papillary adenocarcinoma of the thyroid is identified by papilliferous projections of epithelial cells with abundant evidence of very vascular connective tissue elements. The application of the term "papillary" places the tumor in a specific category. However, the amount of papillary formation is extremely variable in a single tumor or in different tumors. It has been learned that the behavior of the tumor depends more on the presence of the papillary formation than of the solid epithelial element. This solid element appears as uniform areas of epithelial cells arranged in alveolar or follicular patterns. The papillary carcinoma may appear at any area within the thyroid gland or may be contained in whole or in part within an adenoma. On

the Broders grading scale, these lesions are characteristically extremely low grade. They are slow to grow, and a nodule may have been known to be present for many years without appreciable change in size. The ability to metastasize to the regional lymph nodes is notorious, and why the secondary deposits may be much larger than the primary growth remains a mystery.

Incidence

For some peculiar reason the growth appears to be commoner in younger than in older age groups. This has led us to be extremely suspicious of any nodular goiter seen in the Section of Pediatrics. Hayles and associates² have already reported that in the experience of the Mayo Clinic the lesion is three times as common among girls as it is among boys. In the pediatric group, seven of 41 patients had symptoms before their fifth birthday, and it was found that the average duration of the disease before treatment was two and one-half years. In the adult patients it is far commoner to find papillary carcinoma in a single, discrete, hard mass. Clinically, many of these are listed as "discrete adenoma of the thyroid." In some instances the discrete nodule is entirely malignant, showing no evidence of its ever having been an adenoma. In our experience, roughly 10 per cent of the discrete, nodular goiters prove to contain malignant tissue, and a great majority of these are of the papillary variety. In the case of multinodular goiter, for some strange reason the incidence of malignancy is reduced roughly 50 per cent. While the youth factor has seemed to be important, we have also found that more than 35 per cent of patients with papillary adenocarcinoma were 50 years of age or more. However, the fact remains that the average age is still lower than with any other type of thyroid cancer.¹

Surgical Treatment

Surgical treatment will play by far the greatest role in management of these patients because of the uniformly good results. Ideally, the suspicion of the examining physician will be aroused to the point where early surgical treatment is arranged. The surgeon will expose the lesion widely and remove it completely for immediate frozen-tissue diagnosis.

Read at the meeting of the Medical Association of Georgia, Atlanta, Georgia, May 14 and 15, 1956.

With the diagnosis established, the surgeon will proceed with the indicated removal. In a small, isolated tumor we have been well pleased with total lobectomy with complete removal of the isthmus and rather radical subtotal resection of the contralateral normal lobe. This has guaranteed the integrity of the recurrent laryngeal nerves and also of the parathyroid glands to guard against the dread complication of permanent tetany. Myxedema has not stayed our hand from radical local treatment, since it is relatively simple to manage when necessary. Tetany is a vastly different situation and one which we guard against at all costs. In a more advanced case we have not hesitated to include one recurrent laryngeal nerve in the block removed, since it is a small price to pay for complete local removal of cancer. In the majority of instances both recurrent laryngeal nerves may be preserved.

The division of the prethyroid muscles is a routine step. Should there be any question of malignant invasion of these structures, the muscles are removed widely. (Recently we have had occasion to include a part of the thyroid cartilage in the removal and, with modern adjuncts to surgical care, have found this quite feasible.) With the neck wide open, bimanual palpation of the lateral cervical regions (especially the jugular group of lymph nodes) can be reasonably accurate. If any of these nodes are palpable, we have proceeded immediately with neck dissection on that side. A so-called "fishhook" extension of the collar incision, which may be carried as high as the mastoid, if wished, will give excellent exposure for this purpose.

It is at this point that our method of treatment diverges from that in other centers. If only one or two nodes are involved, we have been satisfied to preserve the sternocleidomastoid and all other muscles of the neck along with the spinal accessory nerve. These structures can easily be sacrificed in a classic radical neck dissection when the indications are clear. In our experience it is not always necessary to do this, and in children and young women there is some question as to whether or not it is even justified. In the same light we consider the sacrifice of the internal jugular vein. Theoretically, a more complete removal of lymphatics is accomplished with greater ease when the vein is sacrificed. However, in practice, one can strip the lymphatics very cleanly and still preserve the vein. In men, in older patients, and in patients in whom there is much more extensive involvement or in whom a more malignant process is quite evident, we have not carried out the modified neck dissection but instead have proceeded with the more standard radical block dissection. The disruption of the uniformity of the contours of the neck, the atrophy of the

trapezius region with the resultant deformity and some disability are necessary evils of such an operation, but when indicated we are willing to accept these.

Should the bimanual palpation of the lateral neck regions fail to disclose any suspicious lymph nodes, we have stopped short of the neck dissection. The patient is observed at regular intervals for the next few years. It is surprising how few of these people ever require further surgical treatment. When the dissection becomes indicated, it is then much more evident just which side of the neck should be attacked and how radical the dissection should be. Our reason for a somewhat less radical attack on the lateral neck regions is based on our more immediate concern with the local area. In other words, the tracheo-esophageal lymph nodes, and the tissues in the thymic region and just beneath the upper part of the sternum, as well as along the esophagus, are frequently neglected in discussions of this disease, and their removal is frequently far more important than extremely radical sacrifice of many normal structures at a considerable distance from the primary tumor. Should nodules become involved at a much later date, even though the patient delays reporting for surgical treatment, it is extremely unusual that the nodes cannot be removed completely. With a very low-grade malignant lesion to begin with and an extremely good outlook following rational treatment, we have felt it better to proceed on the modified plan.

Total thyroidectomy has a greater place in the treatment of this disease than was formerly appreciated. However, my colleagues and I do not do total thyroidectomy routinely by any means. Some authorities argue that with a multicentric type of cancer, total thyroidectomy is strongly indicated. With a possibility of injury to the recurrent laryngeal nerves and the even greater possibility of permanent tetany, we have wished to be very certain of our grounds before removing the thyroid completely. Of the 41 children mentioned in the series of Hayles and associates, four had undergone total thyroidectomy. In all four of these, tetany has resulted. In modern-day medical practice, total thyroidectomy may be offered for metabolic rather than anatomic reasons. In that small number of cases in which significant uptake of radioactive iodine has been demonstrated and inoperable or inaccessible distant metastatic lesions are proved, total thyroidectomy provides the quickest and most certain method of producing profound myxedema. This rids the body of all competing thyroid function, so that the secondary malignant deposits may well take up more radioactive iodine and thus be treated in a more effective manner. Unfortunately, eminently successful cases of this type are few and far between.

The incidence of tumor without proved cervical metastasis is very difficult to prove. However, in the group reported by Hayles and associates, 33 of the 41 children had palpable nodes on admission. Fortunately, only nine of the children had proved bilateral cervical metastasis at any time during their entire illness. In the pediatric group it was noted that the same finding existed as we had observed in the adult group; namely, that the involved nodes were usually discrete masses in the paratracheal and lower jugular area. When there was considerable matting of the lymph nodes and multiple nodes were involved, it usually meant a very late stage of the disease.

Postoperative Deaths

In the average patient encountered at operation—and it is to be remembered that one out of two of these lesions comes as somewhat of a surprise at the operating table—the mortality rate is almost exactly that for benign nontoxic adenomatous goiter (a very small fraction of one per cent). In children perhaps more risk is involved if a neck dissection is to be combined with total thyroidectomy, since the problem of an airway becomes acute. We have never hesitated to add a tracheotomy as a part of the planned procedure and would argue for early tracheotomy if ever any question arose. In the 10-year period referred to earlier¹ there was only one postoperative death in the papillary group. The patient had a huge tumor, and considerable cervical dissection was required in removing it. The record reveals that tracheal collapse occurred. Although this was overcome immediately, severe pneumonia developed, which failed to respond to the usual methods of treatment. During this same 10-year period there were five postoperative deaths of patients who had anaplastic (or diffuse) adenocarcinoma of the thyroid, three deaths of those who had adenocarcinomas within adenomas, and one death of a patient having a squamous cell carcinoma of the thyroid gland.

Follow-up Survey

Following our earlier study Beahrs and I found that, in the first five years after treatment at the clinic, 10 patients had died. Of these 10, the condition of four was found to be inoperable on their first visit. One patient later died of distant metastatic lesions. One patient, who had had only palliative treatment at the clinic, died later of the disease. In a very interesting case there was associated hyperthyroidism in addition to the papillary cancer. The patient in this case later died in hyperthyroid heart failure. Two patients died of unknown causes. Most important point of all, in our opinion, is the fact that only one patient died of a local recurrence. From this five-year survey it appears that none

of our patients died for want of vigorous attack on the regional lymph nodes. This is a point on which is based much of our present-day thinking. In other words, if lymph nodes are not involved at the time of the first operation, the most radical dissection possible has nothing to offer. If one or two lymph nodes are involved, a thorough dissection of the neck of a degree short of mutilation would appear adequate.

Survival Study

As Beahrs and I had found in our earlier survey, the outlook after treatment for papillary adenocarcinoma is most satisfactory. This contrasts very sharply with other forms of cancer. The five-year survival rate in our hands for the anaplastic adenocarcinomas was only 10.7 per cent, for carcinoma within an adenoma it was 80 per cent, while for the papillary form it was nearly 90 per cent. Earlier, Pemberton had reported that a study of the papillary group yielded more than 82 per cent 10-year survival.³

On several occasions we have been stimulated to undertake a study to settle this issue. It would be ideal to have a 20-year follow-up study of one group of patients with proved cervical metastasis who had undergone classic radical block dissection of the neck and to compare this with an identical series in which the patients had undergone a more conservative modified dissection. At the present writing no such comparable series have been published. However, Woolner⁴ will soon present the results of treatment in the Mayo Clinic series which will defend our stand.

Radiation Therapy

In an earlier day it was customary to follow all of these operations with some form of radiation treatment. This was predicated on the oft-repeated statement, "Surgery plus radiation yields better results than any single form of treatment." When we reflect on the grossly inadequate course of roentgen therapy formerly employed, we are convinced that it was "token dosage" and had nothing to recommend it. We have become discouraged at the lack of response of the papillary form to external radiation. At present, if the surgeon feels that he has removed all of the grossly diseased tissue, we eliminate radiation therapy from further consideration. The patient returns on a carefully planned schedule, and if at a later date nodules appear anywhere in the neck, further surgical treatment is undertaken. Usually, the masses are operable. If necessary, interstitial radiation may be employed. Only rarely do we resort to extreme forms of external radiation. Radioactive iodine has been disappointing. We still send patients with suspicious nodules for testing with preoperative radioactive "tracer doses." The information obtained from the Geiger counter and uri-

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. . . Papillary Carcinoma of the Thyroid Gland (cont'd)

nary excretion studies is combined with the gamma-graph obtained from the surgical specimen. The therapeutic radiologist then makes the decision whether a significant uptake has been realized. If there is significant uptake, radioactive iodine may be employed later should the occasion arise. Perhaps future developments will be more along these lines.

Summary

1. Papillary carcinoma of the thyroid gland runs a less malignant course than many other cancers.

2. Surgical treatment is the one of choice at the present time. This may be extremely radical when indicated, but in many cases a less mutilating approach will yield equally satisfactory results.

3. The local area is extremely important, so that

the tracheo-esophageal lymph nodes should be included in any surgical plan.

4. In our experience, follow-up studies do not reveal any death which could be traced to inadequate treatment of the regional nodes, even though extremely radical dissections of the neck were not the rule.

Mayo Clinic

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New Method

Friedman Pregnancy Test

JACK C. NORRIS, M.D., Atlanta, Ga.

THE PHYSIOLOGIC REACTION recommended here for determining early pregnancy is a modification of the Friedman test. We have evolved a new approach and procedure by using whole unclotted blood instead of urine.¹ The blood is introduced into the subcutaneous abdominal tissue of rabbits, rather than into the rodents' veins. Six cc.'s of serum can also be used.

The method was originated in our laboratory during a period of trial for several years, 1951-56; and the results were evaluated by the adaptability, ease of performance, and accuracy of the procedure. To date, 1530 tests have been made. The technique is as follows:

"Ten cc. of whole unclotted blood, immediately after removal from the patient's vein, is slowly injected subcutaneously into the rabbit, which is stretched out upon a table, the feet securely held in an assistant's hands. The syringe needle, 21 gauge, is stuck under the abdominal skin, held firmly in place, and the blood introduced cautiously, being certain that all of the blood enters the desired area. A nodule or swelling will occur, but is rapidly absorbed. Thirty-six to 48 hours later the rabbit is anesthetized and the ovaries inspected for hemorrhages. Forty-eight hours after injection is the most satisfactory period."

The virginal adult rabbit is the animal of choice. Although capricious, frogs can also be utilized. Rats and mice are obsolete.

In order to further clarify impressions of the test, which had been made upon records of more than 1,500 cases, as reported previously, 100 unselected consecutive patients have been studied, beginning the experiment in May and ending in September 1956. An analysis of the group follows:

Total number of positives: 39; total early positives: 3.

Total number of negatives: 54.

Total number of doubtfuls: 4.

Correct positives: 42; specificity: 100%.

Correct negatives: 51; specificity: 96%.

Total overall correct tests in 100 patients: 98%.

The accurate results are more than were anticipated, but clearly confirm the efficiency of the method. Moreover, the figures imply that the new technique of using whole blood, after 15 to 20 days missed menstruation, is the most reliable single pregnancy test so far devised for general laboratory use.

The *new method* of using whole blood, in our hands, has the following advantages:

(1) It is economical. The injection of whole unclotted blood, or serum, into the subcutaneous abdominal tissues does not kill the animals prematurely. On the other hand, urine or serum introduced into rabbits' veins often produces violent fatal fits, thus proving costly and vexing to the physician, technician, and patient.

(2) The method is accurate and seldom gives false reactions. When performed 21 days after the last missed menstruation, it is almost specific in action.

(3) The procedure eliminates the necessity of collecting the "early morning concentrated urine." In the human, the pregnancy hormone is constantly in circulation and apparently in increasing amount; therefore, blood for the test may be obtained at any hour the patient is available.

(4) Blood for the reaction can also be obtained in sterile tubes, without preservative, either clotted or citrated, and can be air mailed to the laboratory. We have received a specimen from Africa.

We have been delighted with the reception of the newer technique. Patients do not object to being "stuck" to obtain blood; in fact, they prefer it. The simplicity of the process makes it much easier on the technicians. The elimination of injecting rabbit veins, and the fact that the animals are not prematurely killed, plus the accuracy of the results, make it obviously superior to any other known tests.

490 Peachtree Street, N. E.

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Presented at the 106th Annual Session of the Medical Association of Georgia, May 13-16, 1956, Atlanta, Ga.

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LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

Recovery from Waterhouse-Friderichsen Syndrome Associated with Use of Norepinephrine to Combat Shock

H. B. STILLERMAN, M.D., Atlanta, Ga.

THE MOST SERIOUS complication of meningococcal infection is the occurrence of the Waterhouse-Friderichsen syndrome. The sudden appearance of shock and purpurae in a patient with a severe sepsis heralds this dreaded clinical entity. Treatment of the Waterhouse-Friderichsen syndrome was uniformly unsuccessful until 1940. Since that time, a few scattered reports have appeared in the literature reporting recovery from this syndrome. Recoveries were first effected with the antibiotic and chemotherapeutic agents.³ The advent of the steroids added a valuable adjunct to the therapy of the Waterhouse-Friderichsen syndrome with an increase in the number of patient recoveries.^{1 2 6 7 9} Recently, reports have appeared in which recovery from this illness was aided by combatting the initial period of shock with norepinephrine.^{4 5 8}

Case Report

J. E., an acutely ill 19-year-old college student, was admitted to Emory University Hospital on 2/16/55. The patient had been suffering from a mild respiratory infection for two weeks prior to admission. The afternoon of admission, he suddenly developed chills, fever, abdominal cramping and vomiting. Oral temperature rose to 104.6°F., and he became lethargic. No history of a headache or stiff neck was obtained although he had some pain in his right temporomandibular joint. There was no history of contact with infectious disease or infectious disease agents. Moreover, no history was obtained of a similar acute illness among his friends or in the college at that time. Past history and systemic review revealed that the patient had acute glomerulonephritis five years before, and that subsequently albumin and casts occurred intermittently in his urine.

Physical examination revealed an acutely ill and lethargic young adult male. His temperature was 102.4°F. orally with respirations of 24 per minute and a pulse of 120 per minute. The blood pressure was 130/60. The skin was flushed and a circumoral pallor was present. No rash was noted. A petechia was present in the roof of the mouth. The neck was supple. The fundi were normal to examination. The throat was

mildly infected. A few small post-auricular nodes were felt. Palpation and motion of the right temporomandibular joint was accompanied by pain. The lung fields were clear. The heart sounds were normal and no murmurs were heard. There was slight spasm of the epigastrium. The spleen was not palpated. Neurological examination did not reveal any abnormalities. The remainder of the physical examination was normal.

Admission laboratory studies: Urinalysis—there was a heavy trace of albumin, no sugar, and the microscopic examination of the spun sediment revealed 8-10 rbc's, an occasional wbc and no casts/hpf. Hgb was 14.4 grams; wbc 11,050 with 9 stabs, 85 segmented forms, 1 eosinophil, 5 lymphocytes and adequate platelets. A chest roentgenogram was normal. A throat culture and three blood cultures at hourly intervals were taken.

Due to the acuteness of the illness and the marked shift to the left in the differential count, the patient was started empirically on 500,000 units of aqueous penicillin G every three hours parenterally. During the night, the patient's temperature spiked to 106.6°F. rectally. This was controlled with alcohol sponging and then aspirin. In the morning he appeared much better. There was less lethargy, and his temperature had fallen to 101°F. His neck was supple. He did not have a rash. A WBC and differential at the time revealed a count of 25,00 cells with a marked shift to the left. The NPN was 57 mg%. the morning following admission. At 2:00 P. M. of the second hospital day, 14 hours after admission, the patient became mildly disoriented. He had a few incontinent bowel movements. He was found to have a stiff neck. His temperature at this time was only 100° F. A spinal puncture was performed, and the fluid was cloudy with 10,050 wbc's per cu. mm.—all segmented forms. Gram stain of a spun sediment did not reveal any organisms.

Two hours after the lumbar puncture, the patient suddenly developed a purpuric rash which was most marked on the trunk. His blood pressure dropped to shock levels, namely 60/40. He was not complaining of a headache. The clinical diagnosis of meningococcal meningitis complicated by the Waterhouse-Friderichsen syndrome was made.

The patient was started on fluids, adreno-cortical extracts and blood transfusions. His blood pressure did

From The Department of Medicine, Emory University School of Medicine.

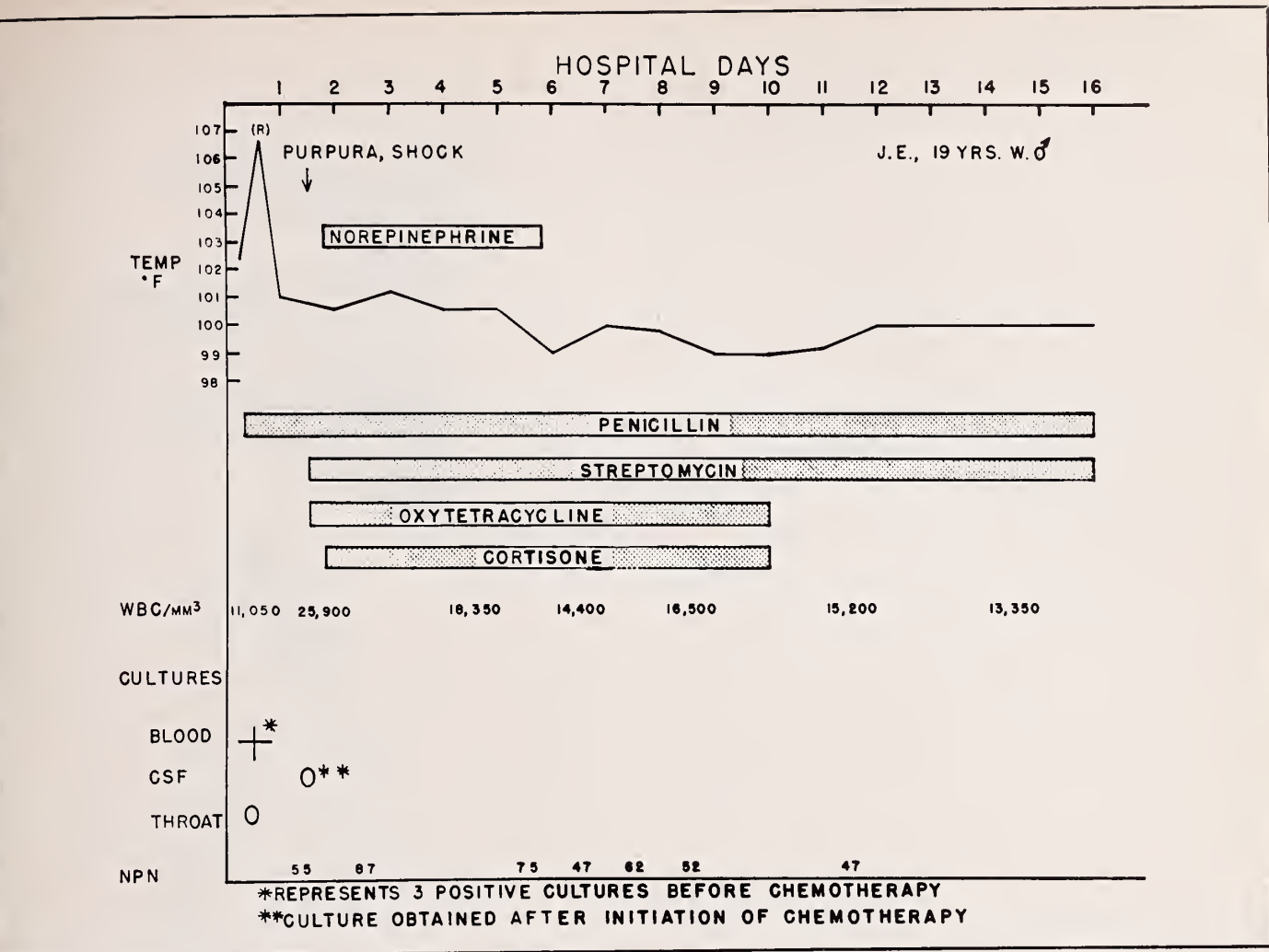


Figure 1

not respond to this therapy. He was then given cortisone parenterally, but his blood pressure could not be brought to levels higher than 80-90 mm. Hg. systolic. Wyamine was then tried with no effect on the blood pressure. At 9:00 P. M., five hours after the onset of the Waterhouse-Friderichsen syndrome, norepinephrine was started in constant infusion. The blood pressure was maintained with relative ease at levels of 100-120mm Hg. systolic. Discontinuation of the norepinephrine was attempted three times during the first 72 hours of infusion with prompt fall in blood pressure readings to shock levels.

Antibiotic therapy consisted of aqueous penicillin—eight million units/day and a battery of antibiotics since the history of glomerulonephritis precluded the use of sulfanomides. He was therefore given streptomycin—one gram/day and parenteral oxytetracycline, 500 mg. every 12 hours.

The patient responded to therapy. The temperature returned to normal levels on the sixth hospital day, the purpura blanched and then disappeared. The norepinephrine was discontinued after 87 hours of continuous infusion. The patient was continued on his penicillin regimen until the day of his discharge, the 16th hospital day. He was then given 600,000 units of benzathine penicillin G parenterally. Streptomycin was discontinued on the 15th hospital day. Oxytetracycline was administered intravenously for four days and then intramuscularly for five additional days.

The spinal fluid cultures did not grow any organisms. The throat culture did not reveal any meningococci but the blood cultures were all positive for *N. meningocociae*. The NPN fluctuated from levels of 87mg.% on the second hospital day to 47mg.% at the time of discharge. Electrolyte studies including sodium, potassium, chloride and CO₂ were all normal. At no time was there laboratory evidence of impairment of adrenal cortical function. The patient was discharged on the 16th hospital day. Figure 1 summarizes the clinical course, treatment, and laboratory studies.

The patient was seen three and nine months after his discharge from the hospital. He had a complete recovery. No abnormal findings were noted. Renal function studies were all normal.

Discussion

The case reviewed is one which is of interest as a study in diagnosis and therapy of an acute fever. Recovery from the Waterhouse-Friderichsen syndrome can probably be traced to the combination of antibiotic therapy, norepinephrine, and steroids. The value of early antibiotic therapy is well illustrated in this case. It is important to point out that diagnostic laboratory studies, i.e. blood cultures, were drawn before penicillin was administered. The establishment of the diagnosis depended on the blood cultures since the spinal fluid cultures did not grow

any organisms. The gravity of the patient's illness was complicated by the fact that there was a history of glomerulonephritis with recent albuminuria. Therefore, a drug of choice, sulfonamides, was omitted. To combat infection in the absence of sulfonamide therapy, a battery of antibiotics was administered. The problem of treating shock was solved by the use of norepinephrine. Neither cortico-steroids nor blood brought the blood pressure to normal levels. It was necessary to continue the infusion of norepinephrine for 87 hours continuously before the patient was able to maintain normal blood pressure levels.

The high mortality rate in Waterhouse-Friderichsen syndrome is due to the sudden onset of prolonged and severe shock. Recovery from this illness depends on prompt therapy of the shock and keeping the patient out of shock until the antibiotics can control the infection. Norepinephrine is the only agent at present which is able to consistently and successfully combat the shock of Waterhouse-Friderichsen syndrome.^{4 5 8} Use of norepinephrine has resulted in an increasing number of reports of recoveries from Waterhouse-Friderichsen syndrome where other agents have failed to bring the patient out of shock.

Summary

A case of Waterhouse-Friderichsen syndrome complicating meningococcal meningitis was successfully treated with massive antibiotic therapy, corticosteroids and norepinephrine. The use of norepinephrine to combat shock of the Waterhouse-Friderichsen syndrome is again emphasized.

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Psychiatry and Religion

HARRY R. LIPTON, M.D., Atlanta, Ga.

PSYCHIATRISTS, LIKE MINISTERS, are forever conscious of and feel the brotherhood of man. Several months ago, in New York, The National Academy of Religion and Mental Health was organized. It aims to sponsor research in the area where religion and psychiatry overlap. President Kenneth Appel of Philadelphia opened with the statement, "Church membership is helping people to live more worthwhile and satisfying lives. Mental health is inseparably intertwined with questions of moral value as well as feelings of guilt, anxiety, and insecurity." Reverend George C. Anderson, associate chaplain at St. Luke's Hospital, New York, stated, "The 325,000 clergymen in the United States, teaching Sunday School and preaching in pulpits, can foster healthy emotional attitudes if they have some knowledge of emotional dynamics. They can bring about a more realistic attitude toward guilt, with less emphasis on sin, while still recognizing its importance."

During the past several decades psychiatry has developed techniques for changing people by talking to them; the techniques used are called psychotherapy. If we investigate, we can readily see that the history of man's efforts to change himself did not begin several decades ago, nor does psychiatry have a monopoly on such efforts. On the contrary, countless men all over the world at all times have endeavored to change themselves and to help others change. Most of these men have related their efforts to some system of thought or belief and some associated ceremonial practices, which together are called a religion. Religion has thus become associated in our minds with a system of thought, especially a system explaining the larger or cosmic phenomena of our universe. Religious experiences have many varieties. In the basic religious experience a person achieves a heightened sense of unity with everyone else, and hence with God. Religious efforts at changing derive from this primary awareness of unity and at the same time strive to promote it. This explains why genuine religious experience resembles a self-fueling fire. From the sense of unity with other things and people arises different behavior toward them, notably the behavior of tender love.

Religion and psychiatry have the same task, that of helping man to be happy. They differ not in their

goal but in their approaches. The basic religious experience brings a sense of unity with everything else—with other people, with other things, and with the whole universe. This experience does not come to one as an escape from the hazards of life. Rather, to those experiencing it, the sense of unity appears as a great enrichment of life, and brings an increasingly constructive attitude towards it.

Psychiatry and religion differ in their appraisal of the psychological needs of humans. Some psychiatrists believe that psychotherapy can somehow be divorced from the problem of values. Neglect of this problem has brought criticism on psychiatry. Religious persons have always believed that a man can, through study, prayer, and introspection, ultimately come to know himself and his true nature better. In contrast, some psychiatrists have lost respect for what one can discover about himself. The study of those religious persons who have observed and changed themselves may teach psychiatrists to cast off traditional restrictions and return to self-study and efforts at self-changing which can arise therefrom.

Religion promises a more abundant life. The promise of a more abundant life has assumed new importance and has become the dominating political and social theme of our time. The desire to get something for nothing permeates society and underlies stockmarket speculation, gambling such as the "bug", sweepstakes, and horse-betting. Parents frequently indulge themselves and their children, and some politicians attempt to indulge the masses. Many individuals believe an abundant life requires some stealing if it can be done within the law or without getting caught and that it is permissible to covet one's neighbor's possessions. Covetousness invariably leads to the destruction of character and creativeness.

An abundant life, psychiatry proves, can never be defined in terms of money. It can only be defined in terms of habits, that is, character. Happiness never resides in what an individual has but in what he does. It never consists of what an individual receives but of what he gives, not necessarily in money, but of himself. It resides in a more active life. It does not come from education but from personality traits which the individual develops. It comes from the extent to which an individual is able to

convert his innate energies into good work habits and effective contacts with his fellowmen. When a person has learned to think more highly of his fellowmen he has also acquired a greater confidence in himself.

Religious belief enables an individual to maintain his equilibrium in the face of the actual difficulties of his life. The adjusted individual feels that he is not an isolated individual but a member of an organized social group. In the life of this group the religious beliefs play an important adaptive role. These beliefs have been slowly developed through the ages as the reaction of humanity to the impact of its environment. Their persistence and continual elaboration indicate their importance to the tribe, race, and nation. In his impotence man has constructed a picture of the world which is being continually modified to make it more adequate to his needs. In order to satisfy the demands of his intellect the picture is modified to do justice to the needs of human nature. In virtue of the latter, man sees the world as a spiritual system permeated with definite values in relation to which he feels he must take a personal stand.

The outlook of the individual may be apparently inevitably tragic in the face of disappointment, hostility of others, illness, loss of loved ones, and poverty. Yet it is possible for the individual, by means of his religious beliefs, to adapt himself to his environment and carry on with a feeling of satisfaction and personal value. The scientist, while allowing these beliefs little place in his scientific work, pays personal homage to them and utilizes them in his personal life.

All religions emphasize the forgetting of oneself in the service of others, not merely believing certain things. Religion is by definition the adherence to certain beliefs or principles. Many churchgoers do not possess religion, and many individuals who have never been to church possess it in the highest form. Whereas some sciences have attempted to emasculate religion, psychiatry is rapidly vindicating its basic assumptions with experimental truths. The findings of psychiatry in respect to personality and happiness are largely a rediscovery of old religious truths. Religion is not necessarily the refuge of the

weak but the weapon of those who would be strong. Religion should be seen as an aggressive mode of life by which the individual becomes the master of his environment. Religion teaches extroversion and socialization. It emphasizes a standard of living. Individuals who believe in religion have significantly better personalities than those who do not.

C. C. Jung, the world famous Swiss psychiatrist and an early pupil of Freud, held that most mental ills came directly from the loss of a religious outlook upon life and that there was and could be no complete cure unless such an outlook were regained. It is to this latter view that most psychiatrists subscribe.

Psychiatry deals with mental illness. It is abnormal guilt feelings, irrational and quite unnecessary, that psychiatrists wish to eradicate and relieve, and not normal guilt. Psychiatrists have no authority or interest in replacing religious confession. No psychiatrist would try to remove those feelings of guilt which generate from conflict with the laws of man or nature. He who commits such offenses and feels no guilt is himself a seriously ill person mentally. Psychiatrists do not advocate divorce, sexual promiscuity, immorality, dishonesty, or any other specific type of conduct. They do not reject those who commit such acts, nor do they condemn them as individuals. They consider them to be sick individuals, in need of treatment.

Individuals receiving proper psychiatric treatment will become healthier persons in every way. They will not be weakened in their religious outlook, but strengthened therein. After all, there can be no real conflict between any truths, since all truth is from God. Those who are mentally ill frequently use religion obsessively or compulsively, or develop abnormal preoccupations and delusions about it. They also develop similar ideas about eating, politics, medicine, sex, and all other aspects of life. Psychiatry cannot afford to overlook the healing power of religious faith any more than those in the field of religious work can ignore the deep understanding of human motives and behavior which psychiatry contributes.

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Medical Education — Difficulties and Disproportion

ON ELECTION NIGHT, November 6, 1956, more than 300 doctors of Fulton County met in a called session of the County Medical Society. The meeting stemmed from a report that Dr. Eugene Ferris, Professor of Medicine and Chairman of the Department of Medicine at Emory University School of Medicine, would be relieved of his chairmanship. Many doctors apparently felt that Dr. Ferris was relieved of his duties "without good reason" and requested that the meeting be called. Because of the fact that more than 200 of the society's members serve on the volunteer faculty of the medical school, it was reasoned that medical school policies are a matter of special interest to the society. Special concern was also voiced by many of those assembled regarding the key role in community health and medical teaching fostered by Emory University at Grady Hospital in Atlanta since 1915. With the opening of the new 25 million dollar Grady Hospital in 1957, much interest was expressed in the projected plans of Emory University and the Hospital Authority for a coordinated community health and medical teaching program. Many speakers were heard, including Dr. Richardson, dean of the medical school, who reassured the gathering that "the Emory Medical School welcomes the concern and counsel of the Fulton County Medical Society. Since both school and society are devoted to the public interest, they have an equally important stake in the integrity and quality of medical education and medical care."

Statements by Dr. Ferris and two other department chairmen indicated that such problems as existed were common to all departments and were not confined to the Department of Medicine.

A statement was made by Dr. R. Hugh Wood, former dean of the medical school, in which he pointed out his conception of the true issues at stake. He noted in a written statement that in the past 14 years "three deans and three professors of medicine have come and gone at the school." He pointed out that Emory Medical School and Grady Hospital have "conducted the joint activity of service to patients, medical education and research since 1915. The problems and difficulties in this joint enterprise have been disproportionate."

He recommended three steps "to end the confusion which is destructive to the purposes of both

institutions." They are: (1) That goals and objectives should be defined. (2) The policy by which the ends are to be attained should be clearly and publicly stated. (3) The administrative procedures and practices under this policy must be outlined.

"The Boards of Trustees of the two institutions must agree to these objectives, policies and practices," Dr. Wood said. "Until a decision on these matters is reached, new appointments to the faculty or administrative positions have little chance of success."

Following Dr. Wood's statement, the Society unanimously adopted a resolution asking the school's Board of Trustees to "reconsider its basic policies and to call into consultation such experts as may seem necessary."

This resolution along with Dr. Wood's statement was forwarded to the Emory Board of Trustees for consideration.

To date the Board of Trustees has not indicated that the society's request to "restudy basic policies" has prompted any action on their part.

On November 12, 1956, Mr. Hughes Spalding, Chairman of the DeKalb-Fulton Hospital Authority, in a speech before the Atlanta Rotary Club, singled out for praise the Emory University Medical School personnel who are on the staff at Grady Hospital. He specifically mentioned Dr. Ferris, Chief of Medicine; Dr. John M. Howard, Chief of Surgery; Dr. William Caton, Chief of Obstetrics, and Dr. Richard Blumberg, Chief of Pediatrics. At one point in his speech, Mr. Spalding said: "I think that our medical care today at Grady is better than at anytime I've been on the (authority's) board. We are all very well pleased with our medical care."

On November 15, 1956, the Health Services Board of Emory University, representing the Board of Trustees, approved a recommendation to it from Dr. Richardson that Dr. Ferris' chairmanship of the school's department of medicine be terminated. Although the Board gave no specific reason for relieving Dr. Ferris of the chairmanship, a statement by Dr. Goodrich C. White, Emory's President, indicated that Dr. Ferris had differed with Emory administrators and trustees on medical school policies. In his statement, Dr. White listed the two "critical points" of the medical school's policies as the organization of the Emory University Clinic, and the development of medical school facilities on the university campus.

It would seem abundantly clear from the foregoing account of developments as published recently in Atlanta newspapers that marked differences of opinion do exist among those whose responsibility it is to administer medical education at Emory University and Grady Hospital. The fine facilities available for the task at both institutions are known to doctors not only in Georgia but throughout the nation. Atlanta is probably as well endowed as any city of its size with a progressive group of trained, competent doctors most of whom should be willing and eager to serve as part-time faculty in a coordinated teaching program.

The doctors of Georgia and many over the nation are watching recent developments with genuine concern. It is imperative that somehow the necessary leadership will soon be forthcoming for a satisfactory settlement of differences and that Atlanta and the Southeast will be able to enjoy the effective use of its unexcelled facilities for medical education and patient care.

The Diagnosis Of Acute Pancreatitis

THE RECOGNITION AND DIAGNOSIS of acute pancreatitis continues to be of grave concern to the physician and surgeon as prompt institution of effective therapy without operative intervention has progressively lowered the overall mortality. This fact makes earlier recognition mandatory and places a premium on the establishment of a correct diagnosis. Fortunately, the incidence of recognition is increasing in almost direct proportion to the incidence of increased suspicion on the part of the physician.

Recognition, however, of acute pancreatitis will never be a simple or straightforward process as there are still many pitfalls. The classic symptomatology of epigastric pain with radiation to the back is frequent, but the acute attack is often impossible to recognize, since the symptoms may vary from vague epigastric complaints to symptoms of profound collapse incident to an intra-abdominal catastrophe. The wide variation of pain localization is easily explained, as the pancreas is a retroperitoneal structure which crosses the mid-line and is supplied by sympathetic fibers which refer pain to the upper quadrant. The ease of explanation of the pain mechanism does not aid in the diagnosis of the individual patient, for the symptoms may mimic those seen in disease of any of the upper abdominal organs.

Just as the pain is variable, so the physical findings may be quite variable from patient to patient. The chemical peritonitis incident to the escape of

pancreatic enzymes within the abdominal cavity may mimic the physical findings of many disease processes.

Radiological studies are only rarely of value in establishing a diagnosis of acute pancreatitis, but they are frequently of value in ruling out the presence of other acute catastrophes. Localized distention of small bowel in the left upper quadrant, displacement of the stomach upward and forward, pleural effusion on the left, pancreatic calcification or enlargement of the duodenal C-loop, are all suggestive that the acute illness is due to disease of the pancreas.

Despite the occasional incident when it is possible to be certain that a patient has pancreatitis on a basis of history, physical findings, and x-ray, the single most useful diagnostic procedure is determination of the level of blood amylase concentration. The patient may be presumed to have pancreatitis, if in the presence of abdominal symptoms and the absence of other positive diagnostic features, the serum amylase is significantly elevated.

Unfortunately, the serum amylase is not a universal solution to the diagnostic problems encountered in acute pancreatitis. The level returns to normal within 48 hours in approximately 40 per cent of all patients, and at the end of 72 hours, 60 per cent of all patients will have a normal serum amylase level. The amylase concentration of peritoneal fluid remains elevated two to four days longer, and peritoneal aspiration may be of aid in difficult diagnostic situations. Unfortunate also is the fact that both serum and peritoneal amylase may be elevated in perforated peptic ulcer, acute cholecystitis, ruptured esophagus, and other diseases which cause upper abdominal pain and which require laparotomy rather than non-operative therapy. In all of the above syndromes there are physical and radiological findings which will almost invariably point to the true diagnosis.

The solution to the problem of diagnosis of acute pancreatitis with present day methods is dependent upon two concepts which the physician should accept—pancreatitis must be suspected in all patients with acute upper abdominal pain or pain of bizarre nature, and a serum amylase must be drawn as soon after the onset of symptoms as possible. It has been found that an extremely high percentage of patients have an elevated serum amylase shortly after the onset of the attack, and on this fact, together with clinical evaluation, rests the basis for the correct diagnosis. Only by the adoption of these two principles, which will lead to the routine emergency use of serum amylase determinations in patients with abdominal pain, will the physician appreciate the frequency of acute pancreatitis. Once the first un-

suspected episode has become recognized by use of this simple, inexpensive laboratory test and a needless and possibly harmful operation prevented, the physician will insist upon amylase determination at the same time the blood count and scout film are obtained in all problems of acute upper abdominal pain. The widespread determination of serum amylase concentration both day and night must become commonplace if pancreatitis is to be recognized and effectively treated.

Jack A. Thompson, M.D.



Automobile Safety Stickers

IT IS QUITE SURPRISING to find that doctors, with their rather high I.Q.'s, rank very low in the list of safe drivers. As one driver-educator put it, "Doctors, lawyers, and scientists do worse behind the wheel than people with nothing much on their minds." Many of us number among our friends some who handle an automobile not as a vehicle but as a deadly weapon.

Safety is not like the weather, which everyone discusses but nobody does anything about. It is something we can, should, and must promote. Your medical association, therefore, is embarking on a program designed to remind not only the physician but every driver that safety can become part of our everyday lives.

When each MAG membership card for 1957 is mailed, one Auto-Safety Bumper Sticker will be enclosed. These stickers will identify you as a physician-member of the Medical Association of Georgia. They will not be available to anyone other than members of the MAG. If an additional sticker is needed for a second car, it may be obtained by sending 50 cents per sticker to the MAG office. Please place the sticker on the rear bumper of your car near the license plate; or on the left side of the

bumper, according to directions enclosed with the sticker.

The sticker is made of a durable material which will last through the life of your car. The surface, except for the lettering, has reflective qualities which make it an additional safety factor for your car. Once the sticker has been in place for a few days, it will be impossible to remove without destroying it.

We trust you will place these stickers in the proper position on your car to identify yourself, first, as a physician; secondly, as a member of the Medical Association of Georgia; and last, but not least, as one who is interested in cooperating in safe driving.

*Christopher J. McLoughlin, M.D.,
Chairman, Public Relations Committee,
Medical Association of Georgia*

Sears-Roebuck Foundation Grants to Physicians

IS THERE A SHORTAGE of doctors in the United States? This question is constantly being asked by laymen. It is indeed a question that inspires politicians to point an accusing finger at the medical profession. Among medical educators, physicians, and laymen associated with the medical profession the answer is that there is no such shortage. They point to an increasing number of young physicians graduating each year. But even though this is the case the question continues to be a "plague on our house."

There are many rural communities in the United States that would like to have a physician. Many of these communities are constantly working to attract doctors to their communities. Unfortunately many of these areas are too small to adequately support a physician. In such cases doctors would be doing little more than first aid. Experience shows that whenever major medical ailments occur rural patients hasten to the city where the medical care and facilities are more adequate. Obviously it is difficult to attract physicians to such communities. Yet these are the very areas that are the "fountainheads" of the physician shortage charge. However, such areas should certainly be differentiated from the needy rural area or small town that can support a physician—and there are many of them.

The quality of physicians and the medical care of the nation are excellent. However, specialization in medicine has dictated that doctors settle in heavily populated areas as well as areas educated to specialized medicine. The combination of specialization and a medically educated population is not solving the medical problem in many areas of the country.

The shortage charge will be with us as long as there is a problem of medical distribution. It will

also be with us as long as patients find themselves waiting for what appears to be an unusually long time. Yes, even as long as it appears that the reception room is always full. It will be with us as long as patients have trouble getting a doctor to visit them at night. Even though such calls are not always necessary, there is nothing that seems more necessary to the person calling. It would appear that this cry of "shortage" shall continue to exist until the problem of medical distribution is solved or improved, despite the fact that we have more and better trained physicians than ever before.

What can be done to improve medical distribution? A small but significant and potential program to improve medical distribution has been developed. In 1955 the Sears-Roebuck Foundation made a grant of \$125,000 to the American Medical Association for the establishment of a revolving assistance fund designed to aid physicians set up practices in areas where there is the greatest need. This grant formed the nucleus of the revolving fund with the assurance of the Foundation that the grant would be continued annually for 10 years as long as there is a need for such a program. A Medical Advisory Board was then appointed to advise and guide the Foundation on all medical matters. It was the feeling of the Board that the revolving fund should make loans—not grants—to physicians. There were two reasons for this. First, loans would hasten the repayment, thus providing greater turnover of funds. Second, without interest the fund would remain at a static level. The interest provisions of the plan provide for the growth potential. This fund, assuming no defalcations, can within 25 years have a potential \$9,000,000. This is approximately eight times the total amount contributed by the Foundation for 10 years.

The fund provides 10-year, unsecured, supplemental loans. They are under no circumstances loans to take the place of loans made by normal lending agencies. In fact, the Sears loan is designed to make up the difference of what can be borrowed through normal lending channels and the amount actually needed. The interest rate is so designed that it ranges from zero to six per cent, depending on the rapidity of repayment. To help those starting their practices, no principal payments are necessary for the first three years, although simple six per cent interest is charged. However, once principal payments begin, interest stops. If one starts principal payments the first month and pays the loan back by the start of the fifth year, there would be no interest charged.

These loans are designed to encourage physicians to go to areas where there is a medical need. The Medical Advisory Board, which decides upon all applications, feels the need is the greatest in rural areas,

small towns, and certainly in the now rapidly growing suburban areas of the nation.

Specifically these loans can be used for new buildings, remodeling, expanding, purchase of existing facilities, and for equipment. However, in all cases, the money lent must be supplemental to what can be raised or borrowed by the physician. This plan is in the development stage and as such does not have tremendous sums available at this time. Thus all who apply are, in effect, in competition with one another. Even so, those who apply are judged on the medical need of the community and the financial need of the applicant. Loans are made where there is the greatest need. Though this is a small plan now, it increases each year and certainly within the next three years the fund will have around \$200,000 a year to loan.

Since the inception of the program, Georgia leads the nation in the number of physicians who have received financial assistance. Loans have been made to a medical group as well as to individual general practitioners. The common denominator of all was the need of the physician. Actually 57 per cent of those applying received loans in Georgia totaling \$37,500.

In order to facilitate the processing of applications the Medical Advisory Board established two cut-off dates for accepting applications. Applications received between April 2nd and October 1st are processed no later than December 15th. Those received from October 2nd up to April 1st are decided upon no later than June 15th.

When the question of need is considered, probably the most deserving are the residents and interns who have just graduated and are at the end of the financial rope. This program can be of value to them. It should also encourage physicians to practice in areas where there is the greatest medical need.

The ideal condition would be to bring a doctor to a community. However, this is not always possible. It is also important to improve the medical facilities of physicians who are already practicing but under poor conditions.

The plan will have been in effect for two years in December. To date the Foundation has made 21 loans affecting 33 physicians in 12 states, totaling \$171,500. Applications are now being accepted for determination in the first half of 1957. This is the ideal time for interns and residents who are graduating to obtain financial help if they can qualify under the needs of medical and financial help. Applications must be in before April 2nd to qualify. Any physician interested in the Sears-Roebuck Plan of Financial Assistance may obtain application forms from the city, county, or state medical society.

*Norman H. Davis, Director
Medical Program, Sears-Roebuck Foundation*

Pulmonary Hypertension

NOBLE O. FOWLER, M.D., and ROBERT H. FRANCH, M.D., Atlanta, Ga.

NORMAL PULMONARY arterial blood pressure is about one-fifth that in the systemic circulation. Pulmonary hypertension is usually secondary to heart or lung disease. There are four major physiological causes of increased pulmonary artery blood pressure. The first cause is an increase in pulmonary venous pressure most commonly produced by (1) mitral stenosis, (2) failure of the left ventricle, and (3) obstruction of the pulmonary veins due to left atrial thrombosis. The second major physiological cause of pulmonary hypertension is obstruction of the pulmonary arterial tree as is commonly seen (1) in thrombosis or embolism complicated by reflex pulmonary vasospasm possibly mediated through the autonomic nervous system, (2) in hypoxia which may increase pulmonary arterial resistance, and (3) in a reduction of the lung vascular bed, as in pulmonary emphysema. The third major cause is increased blood flow through the lungs as is seen in (1) left-to-right shunts, (2) hypoxia, and (3) anemia. Because of the low resistance of the pulmonary vascular bed, increased pulmonary blood flow does not ordinarily increase greatly the pulmonary arterial pressure unless there is additional increase in pulmonary vascular resistance. Finally, an increase in pulmonary blood volume may increase pulmonary pressure as occurs in (1) polycythemia, (2) acute glomerulonephritis, and (3) infusions of dextran.

Clinical features that help in estimating the presence of pulmonary hypertension are a loud pulmonary second sound and a pulmonary diastolic murmur. In addition, there may be a systolic sternal lift to suggest right ventricular hypertrophy, tricuspid insufficiency to suggest right ventricular dilatation, and there may be evidence of right ventricular failure. The appearance of cyanosis and polycythemia in primary pulmonary hypertension, atrial septal defect, or chronic pulmonary disease may suggest the diagnosis of pulmonary hypertension. On x-ray, evidence of right ventricular enlargement and a large main pulmonary artery with small tertiary

branches is helpful; the presence of the transverse basal septal lines occurring especially in mitral stenosis suggests long standing pulmonary congestion and pulmonary hypertension. Electrocardiographic evidence of right ventricular enlargement is a valuable clue. Direct measurement of the pulmonary artery pressure is done by the cardiac catheter or needles at operation. The pulmonary wedge pressure reflects variations in pulmonary venous pressure and provides an important aid in differentiating between two physiological mechanisms that produce pulmonary hypertension. The pulmonary wedge pressure is elevated in pulmonary hypertension due to left ventricular failure or mitral stenosis but is not expected to be elevated in pulmonary hypertension due to chronic pulmonary disease or in idiopathic pulmonary hypertension.

Idiopathic pulmonary hypertension makes up a very small portion of the total cases of pulmonary hypertension. It is a condition of unknown cause seen mostly in children and young adults. The symptoms are more commonly those of exertional dyspnea and of syncope on effort, and there is predisposition to sudden death, possibly the result of ventricular arrhythmias. Cyanosis is absent early; right heart failure may develop. Cyanosis may occur either as a result of peripheral stagnation due to heart failure or to opening a patent foramen ovale by increased right atrial pressure when the right heart begins to fail.

Unlike essential hypertension, then, most causes of pulmonary hypertension are of known cause and the treatment depends chiefly on the treatment of this precipitating cause. If due to left ventricular failure, the management of congestive heart failure would be in order; if due to mitral stenosis, possibly commissurotomy should be done; if due to left-to-right shunt, closure of the shunt may be indicated. In pulmonary hypertension secondary to chronic pulmonary disease, infection needs to be treated, bronchospasm relieved, oxygenation improved, watching for depression of breathing due to carbon

Prepared at the request of the Committee on Professional Education of the
Georgia Heart Association.

Federal Medical Spending

Washington, D. C.—Federal health and medical spending for all agencies of government this fiscal year is expected to reach a new high peak. The total is placed at \$2,558,719,168, an increase of nearly 13% over the last fiscal year, which itself set a new record.

The spending is spread among 21 departments, agencies and commissions concerned in whole or part with health or medicine. They range from an impressive \$825,024,300 for the Veterans Administration to a small sum of \$12,145 for running the Office of the Attending Physician of Congress.

The medical budget total, divided into cost for each man, woman and child in the country, amounts to \$15.17 a year, while each family in the U. S. will be paying \$54.61 for this spending, based on Census Bureau figures for population, family size and employment.

Compared with last year's spending, the Defense Department has dropped to second place with its spending estimated at \$790,105,000, thus giving way to the VA. The Defense Department shift from the top spending spot, despite a \$41 million item for the new dependent's medical care program, is due primarily to more effective joint utilization of facilities, fewer personnel assigned to operation and a planned drop in hospital and dispensary construction.

Department of Health, Education, and Welfare spending for the year ending next July 1 amounts to \$772,661,800, which puts that agency's total within striking distance of the two top spenders in the health-medical field. Compared with last year's \$526,935,400, HEW spending this year is up a resounding 46%, due in part to more Hill-Burton hospital construction money, record research funds, and permanent and total disability payments.

Following is a table of spending by the 21 agencies this year and last:

AGENCY	FISCAL 1957	FISCAL 1956
Veterans Admin.	\$825,024,300	\$790,185,800
Dept. of Defense	790,105,100	818,104,500
Dept. of Health, Ed. and Welfare	772,661,800	526,935,400
Federal Civil Defense Admin.	49,810,000	30,450,000
Atomic Energy Commission	31,525,000	27,700,000
International Coop- eration Admin.	29,310,000	25,441,000
Dept. of State	15,496,000	13,669,790
Federal Employees Health Program	10,000,000	6,000,000
National Science Foundation	8,000,000	5,000,000
Dept. of Labor	7,151,126	7,336,000
Dept. of Interior	6,138,205	5,770,000
Panama Canal Zone	6,055,300	5,702,900
Dept. of Treasury	3,511,700	2,990,000
Dept. of Justice	1,580,000	1,470,000
Federal Trade Commission	1,000,000	1,000,000
Dept. of Commerce	547,914	277,586
Civil Service Commission	386,000	382,600
National Advisory Committee to Selective Service	180,000	180,000
President's Comm. for Handicapped	134,678	130,000
Health Resources Advisory Comm.	90,000	101,000
Office of Attending Physician of Congress	12,1454	-----
TOTALS	\$2,558,719,168	\$2,268,826,576

. . . Heart Page (cont'd)

dioxide narcosis, mechanical respiratory aids and breathing exercises may be needed. Activity may need to be very restricted. Phlebotomy is of questionable value in some people's opinion; the hematocrit is brought down usually to about 50. Postural drainage, bronchoscopy, and tracheotomy may be needed. Patients with heart failure secondary to pulmonary hypertension should be treated in the usual manner. It is not true that these patients do not respond to digitalis. In primary pulmonary hypertension, treatment is very difficult, and marked re-

striction of activity is indicated; these patients do not respond well to either sedation or anesthesia. It is known that Priscoline intravenously lowers the pulmonary artery pressure in these patients. Whether or not the clinical administration in doses of 50 mg. four times a day has much to offer is in doubt; however, this may be tried. In the future, operations on the autonomic nervous system may have something to offer in primary pulmonary hypertension.

69 Butler Street, S.E.



president's letter

OPINIONS AND INFORMATION about the status of anesthesiologists, roentgenologists, and pathologists given in the questionnaires and in personal letters from doctors from all our states and territories showed not only that opinions vary enormously and that some are exact opposites, but that in some instances their knowledge is incomplete about what is going on in their own states and even in their own cities.

Ideas vary about what is proper and ethical among doctors in the same town, and there is some difficulty concerning these matters in practically all states.

Much of what is happening is not being dictated by what is considered ethical and legal, but by financial and economic conditions and by what is expedient in the individual case.

Anesthesiologists

The national society of anesthesiology, some state organizations, and some local groups do not allow their members to work on a salary. They work as private physicians and bill their patients for services, as do other physicians. And, as do other physicians, in various hospitals, they serve the indigent patients without charge.

In many states and in many cities, some work on salary, some on a percentage of charges made by the hospital, some on a salary plus percentage, and some send their own bills.

In some hospitals, doctors on the staff, or residents or interns, give the anesthetics. In some hospitals there is a closed staff, but in most of them a surgeon may have any anesthesiologist he desires.

In these answers there was some protest against an anesthesiologist's being considered a private doctor, the idea being that he only administered medicine for the relief of pain and was practically on a par with a nurse giving a dose of morphine under the directions of a doctor. Some stated frankly that the hospitals depended on the department of anesthesiology for financial support, and that in general the attitude of a doctor toward the ethics of the situation depended on his pocketbook. One doctor mentioned an anesthesiologist who bitterly fought using nurse anesthetists until he himself conceived the idea of hiring them, which he did, finally having five working under him. He charged fees for their services, paid the nurse-anesthetists their salaries, and profiteered off their work. In addition, he had

a big fight with the insurance companies, demanding that they pay his nurse-anesthetists the same fee that they did him.

Nurse-Anesthetists

Although the practice is frowned upon in areas where there are enough anesthesiologists to meet the needs, it is considered ethical to hire nurses on a salary practically everywhere. In some hospitals they work under the supervision of an anesthesiologist, but in others the surgeon who operates assumes the responsibility for their work.

Some doctors stated that they preferred nurse-anesthetists to anesthesiologists. Some doctors stated that hospitals preferred having nurse-anesthetists because they made a financial profit off their work.

Roentgenologists and Pathologists

The criteria for certain desirables in the department of radiology and pathology in any hospital have been laid down by various societies. In the first place, these departments should be under the direction of a qualified radiologist or pathologist who is responsible for all the activities of his department, and no third person, administrative or otherwise, should determine the type or extent of the service.

The fee charged for service of any kind must be sufficient to cover the overhead items necessary for the total work, including payment to the hospital for the space used, the material used, machinery used, salaries of technicians, and for the compensation for professional services rendered by the doctor himself. The hospital should neither take nor be given any part of this compensation for professional services. If this should happen, the hospital administration would always be tempted to direct the department in the interest of increasing hospital income, rather than for effectiveness of medical service to the patient.

The patient is not being treated honestly if any part of the fee that he believes he is paying for radiological or pathological services is going to other services.

Roentgenologists and pathologists are bound by the code of ethics, just as other doctors. They should be known as specialists practicing in the hospital.

According to these criteria, the most satisfactory arrangement would be the leasing of the space and equipment by the roentgenologist or pathologist, for which he would pay a monthly rental. Next in

This is the third in a series of articles based on a survey carried out by Dr. Davison. The first appeared in August and the second in November 1956.

line of desirability would be the payment to the roentgenologist or pathologist of a percentage of gross income, ranging from 40 to 65 per cent, depending on the size of the hospital, the amount of work being done, and the overhead cost. It is not considered desirable that the roentgenologist or the pathologist be paid a percentage of net, which nearly always results in fee splitting, and often a physician is chosen on the basis of this percentage, rather than on his professional qualifications.

Also, it has been shown in some instances in which the financial remuneration a doctor receives is based on the percentage of net, the administration piles on extra expenses of various kinds which are not justifiable under the circumstances. The hiring of technicians and other personnel in the department should also be under the management of the doctor, who is more apt to see that he obtains technicians who are competent. The roentgenologists or pathologists should not be overworked. If a roentgenologist or pathologist by his own agreement desires to use part of his personal income for research work or for development within the department itself, this is justifiable and is ethical. This must be done on the initiative of the individual doctor.

On November 28th, 1955, the Judge of the District Court of the State of Iowa issued a ruling that the hospitals in the state of Iowa cannot employ physicians and pathologists and roentgenologists and bill patients directly for their services. The judge ruled that this constitutes the corporate practice of medicine and is illegal in the State of Iowa. The State Attorney General had already ruled the same. The court held that work being done by roentgenologists, pathologists, and by the technicians under their direction, constituted the practice of medicine. Under the law, the privilege of the practice of medicine is a personal one, requiring qualifications which cannot be met by any corporation. Hospitals can own a department of roentgenology or pathology and maintain these facilities and receive just compensation for their use. The hospital can act as a collecting agent for pathologists and roentgenologists, but the physician's name and his fee must appear on the hospital statement, and it must be made clear to the patient that the hospital is merely acting as the collecting agent.

The attorney general for the State of California had already held specifically that a hospital corporation may not employ physicians on a salary and then charge patients fees for services rendered by such physicians. He has ruled that these hospitals are unlawfully practicing medicine, and he also holds that the roentgenologists and pathologists who serve on a salary in these hospitals are violating the medical practice act because they are aiding

and abetting an unlicensed person or corporation to practice medicine.

Presumably, if the rulings of the Court of Iowa and of various attorney generals are taken to the Supreme Court and sustained, then in all states which have laws against the corporate practice of medicine it is going to be held illegal for any hospital to hire any doctor on a salary, provided it charges for his services, and the medical societies themselves must consider it unethical if the doctors work on a salary.

These matters are being debated all over the United States and must come up for settlement in every state. Individual doctors hold many different opinions. Many stated that any trouble arising between hospital management and roentgenologists and pathologists is always due to a lack of understanding and may be because one or the other is unconsciously trying to exploit the situation.

Many physicians stated they considered a salaried position ethical if the salary were adequate and the number of doctors sufficient to take care of the work load—in other words, if there were no actual exploitation of the doctor.

In some hospitals, roentgenologists and pathologists are allowed to receive referred patients from outside as private ones, charge a fee for services rendered, and pay the department of the hospital for the use of the machine and supplies. Some roentgenologists and pathologists who are not working in hospitals, but have private offices outside, are very much against this practice and state that a doctor working in a hospital should not take private patients that could be referred to private roentgenologists or pathologists outside.

In one city an unusual situation exists in the hospital where four roentgenologists work, each one doing one-fourth of the charity load. Each one of these doctors is an independent practicing roentgenologist, and the members on the staff have free choice of the radiologist they desire. Each of the four receives his pro-rata share and pays in a percentage of his collections for the overhead expenses of the laboratory.

In some localities the hospital collects the fee for the roentgenologist and pathologist, and in others, the name of the roentgenologist or pathologist appears on the bill with the amount due them, so that the hospital will not be considered as practicing medicine.

In all states the roentgenologists and pathologists work on a salary in medical colleges, in charity hospitals, and in public institutions of all kinds. Some doctors express their opinions very freely. One stated that when a physician is given a monopoly of a certain type of service in one particular

hospital, with the absence of a free choice of a specialist in this line, this fact places some of the responsibility on the hospital itself; and the hospital should be compensated for taking the responsibility for this service.

Some doctors stated that they thought it would be all right for a roentgenologist or pathologist to work on a salary, provided other doctors in the institution also worked on a salary.

Another doctor said that the negotiations between the hospital and any doctor are confidential, their own concern, and nobody else's business.

Others stated that doctors should be considered free agents, and if they choose to work on a salary and have signed a contract, that is their personal business; as long as they adhere to the contract and the hospital does the same, both the doctor and the hospital ought to be satisfied.

Other doctors resented the fact that there were the high charges for x-ray services and laboratory services in the hospitals. It was another's opinion that any disputes between physicians and hospital management should be settled by a board or committee from the local or state society or from a national society. This doctor said that fundamentally all these problems come back to a matter of integrity. Whether he was insinuating that we, as doctors, have integrity or do not have it I don't know, but he went on to say that what supposedly involves ethics actually concerns economics and, in addition, false pride.

Another doctor considered anesthesiologists, roentgenologists, and pathologists as technicians, although they have medical degrees. He said that these doctors do not practice medicine in the ordinary sense of the word and he had never heard of any working scheme that would be practical by which they could render bills individually and separately from hospitals or other institutions.

Others considered the services rendered by roentgenologists and pathologists as indirect services, sometimes with the doctor never seeing the patient and the patient never seeing the doctor. He considered that these services were part of a hospital function rather than the practice of medicine and that in most instances the patients themselves have no choice in the matter of physicians. Some of the doctors referred to roentgenologists simply as a "picture taker." Many of them referred to the practice of roentgenology and pathology in a hospital as the captive practice, since it is impractical for another doctor to come in and do the work in a hospital or for the patient to be taken out of the hospital to other laboratories.

Others say that if there be any excess in the charges to the patient, that this excess should be

used to reduce the cost to the patient, rather than to run the hospital. Others think that if there be an excess from either one of these departments, it is all right for the money to be turned over for general hospital purposes, for the use of indigent patients, or for research work.

Another one stated that he himself had never found anything in official printing to state that the hiring of doctors by hospitals is unethical. Another one stated that although the practice might not correspond exactly to the interpretation of the ethics of the American Medical Association, and to certain state laws, that he couldn't see anything wrong in a doctor's hiring himself out to a hospital or medical school, or to a corporation, if he himself so desired.

Some doctors, however, discussed the indifference of their fellow physicians and their societies by saying that as a rule the doctors and the societies themselves are not affected by a particular problem, they seldom go to any trouble to take a stand about it.

Some of the roentgenologists and pathologists have stated that the general mass of medical men are somewhat jealous of the rise of the roentgenologists and pathologists and of their prerogatives; they ignore the plight of those who have to deal first hand with hospital boards, and not only that, they often conduct a rather acrimonious battle against them rather than with them. They say that roentgenologists are working to receive the proper recognition in their various fields. If they are going to achieve their results, they must have the wholehearted support of the medical profession, which they feel at present they do not have.

Lay boards do not have the proper perspective about the work of these specialists. They can't assay the time involved or the responsibility which these men must take.

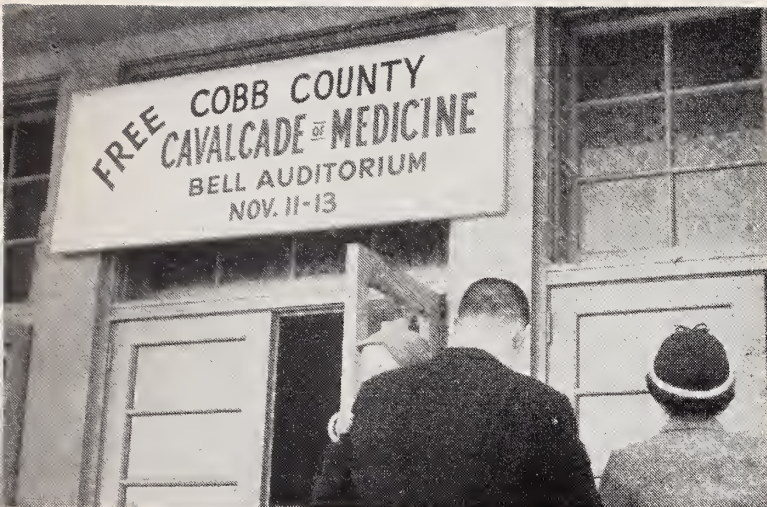
Once again we see a marked variation of opinions in the members of our profession concerning what is legal and ethical in the work of anesthesiologists, of roentgenologists, and of pathologists. The closeness of the doctor to the problem, his status in medicine as a whole, his age, and his economic position all influence his personal interpretation of the law and the code of ethics. At the present time the societies of anesthesiologists are the best organized. It may be predicted, however, that very soon there will be a closer organization of roentgenologists and of pathologists, with a definite stand being taken against institutions hiring these doctors on salaries, with the exception of teaching institutions, charity institutions, and of public institutions.

Hal M. Davison, M.D.

President

Medical Association of Georgia

Cavalcade Cobb County Nov. 11-13, 1956



COBB COUNTY'S RECENT CAVALCADE OF MEDICINE was the biggest thing to hit Marietta since the Lockheed bomber plant was built. People are still talking about it and wondering when the next one will be held. Evidence of its success is shown by the figures: over 20,000 people came during the three days; 80,000 pieces of literature were taken; 2,500 blood typings were done; 1,000 chest X-rays were made; 15,010 free Coca-Colas were dispensed; over 20,000 people went away tremendously impressed, feeling they had learned something important about themselves, their illnesses, and their doctors.

Elmer Hess, past president of the A. M. A., speaking about Los Angeles County Medical Society's Cavalcade last January, said, "If I had my way, every county medical society in the country would do what L.A. has done." He said any medical community which doesn't seriously consider the idea is missing out on a sure-fire bet. The Cobb County Medical Society took him seriously and agrees with him 1000%. Even the most skeptical doctors were overwhelmed by the public's great interest and enthusiasm and response. Your community will be equally enthusiastic.

If your society would like to undertake such a project we would make the following suggestions:

1. Obtain the complete cooperation of your medical auxiliary. They are invaluable in coordinating personnel and schools, publicity, mailing and distribution, manning some exhibits, etc.



of Medicine

Medical Society

Marietta, Georgia

2. Obtain the complete support of your hospital. Many of your exhibits will require hospital equipment, facilities, and personnel.

3. Obtain majority support of your medical society. The doctors will have to plan and man some of the exhibits, make speeches, have a few meetings, and lose some time from their practice.

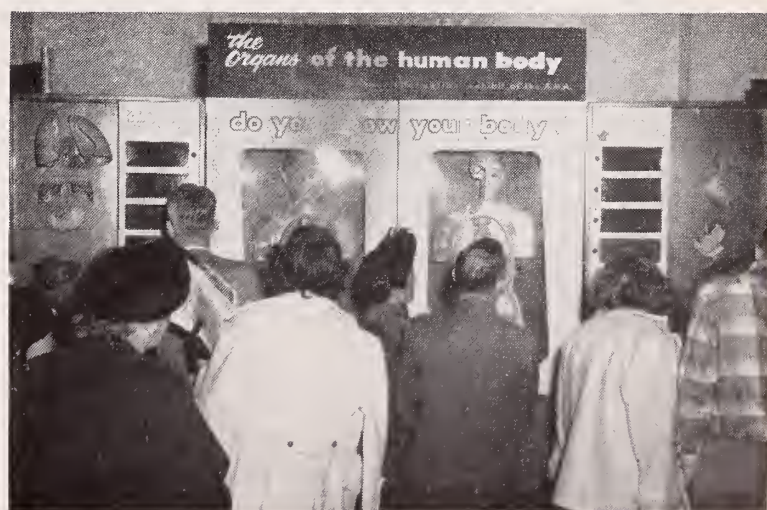
4. Through your publicity committee obtain support from your newspapers, radio and TV stations, schools, Chamber of Commerce, etc.

5. Your best exhibits will be those you plan yourself. Our most popular exhibits were blood typing, operating room, pathology, plastic surgery, historical, neurosurgery. Excellent exhibits are available from AMA, medical schools, and doctors who have exhibited previously. Less popular ones may be obtained free of charge from Red Cross, Army, Public Health, etc. Avoid placard-type displays at all costs. Put something else in it (they put a monkey in one).

6. Start plans eight or more months in advance.

7. Finance it with contributions or rent for exhibit space from ethical drug houses. Local druggists might want to share. Cobb charged no admission, had no axe to grind. The Society donated \$900 to cover the balance, and they say they could have gotten off lighter with better foresight.

8. Anticipate big crowds and a big success.



abstracts by georgia authors



Skelton, Floyd R., 3516 Prytania St., New Orleans, La. "Experimental Hypertensive Vascular Disease Accompanying Adrenal Regeneration in the Rat," *Am.J.Path.* 32: 1037-1053 (Sept.-Oct.) 1956.

Hypertension and widespread necrotizing vascular lesions, resembling those found in malignant hypertension in the human being, occurred in uninephrectomized rats allowed one per cent sodium chloride to drink following unilateral adrenalectomy and contralateral adrenal enucleation. These changes developed as the adrenal cortex regenerated from the capsule and adherent cells of the zona glomerulosa of the enucleated gland.

This communication describes in detail the morphologic changes observed in the kidney, heart, aorta, brain, adrenal capsule, mesentery, pancreas, thymus, ovary, liver, and spleen of rats made hypertensive by this method.

The experiment demonstrates a new technique for the production of experimental hypertension and vascular disease in the rat. The observations strongly support the hypothesis that altered adrenocortical function is of fundamental importance in the pathogenesis of this disease. In addition, it is shown that non-specific, exogenous stress is not needed to produce experimental disease of this type, and indicates that the stimulus to abnormal adrenocortical function can be entirely within the organism.

Shea, Patrick C. Jr.; William A. Reid; & Albert H. Wilkinson Jr., 69 Butler St., S.E., Atlanta, Ga. "Use of Rayon Mesh in Skin Grafting and Granulating Wounds" *Surg., Gynec. & Obst.* 103:241-243 (August) 1956.

Wide experience with a new type of dressing is described by the authors. The material is a rayon mesh and is non-adherent. The mesh is so constructed that it permits rapid drainage of wound exudate into secondary and superimposed dressings, thus avoiding maceration. It has proved to be particularly adaptable to skin grafting procedures and the re-dressing of granulating wounds.

Exact technics for its use are described and also demonstrated by illustration. Lack of toxicity and allergic reactions are substantiated by previous animal experiments and also in the close observation of the cases studied which are the basis for the article.

Maximum benefit from the use of rayon mesh is obtained when the technic devised by the authors is utilized.

Smith, C. Conrad, Southern Finance Bldg., Augusta, Ga. "Prednisolone Ointment and Hydrocortisone Ointment," *A.M.A. Arch. Dermat.* 74:414-415 (Oct.) 1956.

Forty patients with various skin diseases were treated with 0.5 per cent and 0.25 per cent prednisolone ointment. A control study with one per cent hydrocortisone ointment was done, using the method of simultaneous symmetrical paired comparison. Predni-

solone ointment was less effective than hydrocortisone ointment in 23, equally effective in 13, and more effective in four of 40 patients with a variety of skin diseases included in the study.

The results of this limited study indicate that although prednisolone ointment 0.5 per cent is of value in a similar group of skin diseases, it is less effective than one per cent hydrocortisone ointment.

Corpe, R. F.; J. L. Shek; and J. A. Cope, Battey State Hospital, Rome, Ga. "An Experience with Segmental Resection in the Treatment of Pulmonary Tuberculosis," *Dis. of Chest* 30:183-193 (August) 1956.

We reviewed 182 consecutively treated patients who had segmental resections; 99.7 per cent had moderate or far advanced pulmonary tuberculosis upon admission, and 89 per cent had positive sputum. Ninety-two per cent had been positive during preoperative treatment while 57 per cent were positive within a six-month period prior to surgery. All had similar therapy.

The early mortality rate was 1.1 per cent. The morbidity rate was 20 per cent. All complications, except two cardiac arrests leading to death, were otherwise amenable to further treatment.

At present eight (4.3 per cent) of the 182 patients are treatment failures.

Of the remaining 176 patients, follow-up revealed that 49 were still in the hospital with an average post-surgical stay of eight and a half months and the therapy was successful on all up to that point. One hundred twenty-seven discharged patients had an average follow-up after surgery of 22 months. We were unable to secure information on 23 (10.7 per cent) of these patients.

Analysis of the 106 patients followed accounting for 85 per cent of the total, makes us enthusiastic about the use of segmental resection in the treatment of tuberculosis. It is a safe procedure, mortality is low, and morbidity rate is acceptable with few serious complications.

Pennington, Claude L., 1161 Nottingham Dr., Macon, Ga. "Paranasal Sinus Changes in Fibrocystic Disease of the Pancreas" *Arch. Otolaryng.* 63:576-579 (June) 1956.

Fibrocystic disease of the pancreas is not an uncommon disease. It is present once in every 600 to 1000 births and in three per cent of unselected pediatric autopsies.

Exact cause of the disorder is unknown, but it has been attributed to:

1. Prenatal pancreatic infection with post natal deficiencies as a basis for all ramifications of the disease.
 2. Parasympathetic dominance.
 3. Familial and congenital origin.
- (a) With primary pancreatic involvement and secondary organic changes elsewhere.
- (b) A disease of primitive entoderm,

the pancreas being but one of the organs involved.

The author adheres to the last theory (3-b) and produces evidence to support a unifying concept of generalized glandular dysfunction as a basis for all forms of the disease.

A brief review of the generalized disease is presented, followed by illustration of microscopic sections of normal nasal mucosa and nasal mucosa from fibrocystic cases. Bronchial mucosa from fibrocystic disease and nasal tissue from fibrocystic cases are compared to show the resemblance. Histo-pathologically.

Therapy of a previously unrecognized phase of the disease sinusitis, is discussed. Most deaths from fibrocystic disease are pulmonary rather than pancreatic and maintenance of a relatively clear upper respiratory tract is necessary to reduce the incidence of recurrent pulmonary infections.

The case report of a child with fibrocystic disease having gross nasal pathology is discussed.

Tager, Morris, Division of Basic Health Sciences, Emory University, Ga. "Studies on the Nature and the Purification of the Coagulase-Reacting Factor and Its Relation to Prothrombin," *J. Exper. Med.* 104: 675-687 (Nov.) 1956.

The identification of the plasma component (coagulase-reacting factor, CRF) reacting with staphylocoagulase to effect the clotting of blood is a prerequisite to the elucidation of the mechanism of the clotting action of this bacterial product. The fact that coagulase is active in the presence of heparin, and of citrate and oxalate ions, has from the start distinguished its coagulating function from the physiological clotting pathways. The identity of CRF and prothrombin at first appeared to be unlikely when it was found that repeated Seitz asbestos pad filtration achieved a dissociation of the two activities. Starting with such filtrates it has been possible to purify and to concentrate CRF by selective elution with phosphate buffers from celite-amphogel columns. On paper electrophoresis, such products were localized between the beta and the gamma globulin zones, and had on ultracentrifugation molecular weights of about 35,000. When, however, highly purified human prothrombin preparations of Seegers were tested, these likewise reacted briskly with coagulase, but fell in the alpha globulin zone on paper electrophoresis, and had molecular weights approximately twice that of the CRF obtained from filtered plasma. It has further been found that a prothrombin derivative, "autoprothrombin," of Seegers likewise reacted with coagulase. The evidence presented therefore suggests that CRF can be identified with prothrombin as well as with smaller globulin molecules which may well represent split products of prothrombin intermediate between it and thrombin.

Bennett, R. L., Warm Springs, Georgia, "Evaluation of End-Results of Acute Anterior Poliomyelitis," *J.A.M.A.* 162:851-853 (Oct.) 1956.

We must not judge the effectiveness of treatment by setting forth a list of functional activities and arbitrarily deciding that a good result means the accomplishment of a high percentage of these activities and a poor result the accomplishment of but a few. A good result or a poor result depends entirely on what was done with what was left to work with, not in terms of the percentage of normal capacity regained but in terms of the maximum response such involvement will allow under what might be considered ideal circumstances. Many results that might be considered poor when compared to the average response, might actually be excellent if we consider the odds against which these particular patients were fighting. On the other hand, results quite acceptable to average patients should be considered poor if the patients evaluated have had every advantage and have made little use of them. Five factors determine recovery: (1) site and extent of central nervous system involvements; (2) availability of adequate medical care; (3) medical condition of the patient, particularly during the first six months after acute onset; (4) age of patient at onset; and (5) personality of patient, his family, and his community.

The effectiveness of treatment may be judged on six points: (1) the pattern of residual weakness; (2) the residual musculo-skeletal deformities; (3) the type of apparatus used; (4) the types of orthopedic surgery required; (5) evidence of specific functional training; and (6) the attitude of the patient towards his handicap.

Martin, J. D., Jr., Emory University Hospital, Emory University, Ga. "Vesicocolic Fistula Complicating Diverticulitis of the Colon" *Am. Surgeon* 22:645-651 (July) 1956.

Vesicocolic fistula is the most disabling complication of diverticulitis of the colon. This will increase with the frequent perforations, abscesses, and obstructions, which follow in their order of occurrence. Interest in this problem is centered in previously asymptomatic

patients who incidentally are encountered with acute manifestations.

This condition most frequently occurs in obese men past the age of 40 years. Diagnosis can be made by barium enema, cystoscopy, a cystogram and frequently with the use of oral dyes.

The gross pathologic appearance may be like that seen in low grade epidermoid carcinoma involving the bladder. For that reason, when at cystoscopic examination such evidence is found a barium enema should be done to exclude diverticula of the colon.

Resection of the involved segment of the bladder and the colon constitute the necessary means of correction of this disease. Preliminary colostomy is best instituted in those associated with marked acute inflammation. Primary resection may be safely performed in the chronic stage.

Prophylactic resection of the colon with acute or chronic diverticulitis, with obstruction or hemorrhage, should prevent this type fistula. This has been made possible by the use of adequate preoperative antibiotics, sufficient fluids, electrolytes, and blood.

Perkinson, Neil G., Medical Arts Building, Atlanta, Ga.; Walter W. Brandes and Frank P. Shepard, Jr., New York, New York, "Axillary Node Examination in Breast," *Arch. Surg.* 73:828-832 (Nov.) 1956.

The authors seriously questioned their own technique of examining mastectomy specimens when a widely-quoted report by Saphir and Ambromin showed 33 per cent of cases to have involved axillary lymph nodes only on serial sectioning after routine sectioning had shown them free of metastases.

In the present authors' study, of 37 axillary specimens subjected to a clearing technique, search for lymph nodes and single sectioning of these nodes, only one case had a change in prognosis.

Of 35 cases in which all nodes seen on single sections not to be involved by metastatic breast cancer and undergoing sectioning serially, only two cases had their prognosis changed, and in one of these, serial sectioning of the nodes found on routine search

without clearing would have proven sufficient.

Each of these additional methods of studying lymph nodes is found too time-consuming and otherwise expensive to be of value as a routine method. Indications are that the best practical method of determining axillary metastasis consists of a very careful initial search for nodes, employing if necessary a strong background light and perhaps making three or more sections from each node found.

Martin, J. D., Jr., Emory Hospital, Emory University, Ga., "Massive Upper Gastrointestinal Bleeding" *Am. Surgeon* 22:606-607 (June) 1956.

Acute gastrointestinal hemorrhage is second to an acute abdomen as a cause of concern. There are three basic problems: (1) determination of the cause of the bleeding, (2) a decision as to whether conservative blood replacement or operative measures are indicated, and when is the optimum time, and (3) what procedures are available for the control of bleeding and when should definitive therapy be instituted.

Some confusion exists regarding indications for operation but there are three definite reasons: (1) In spite of early and full blood replacement cannot maintain blood pressure from blood loss, (2) those with massive bleeding and who cease and hemorrhage before leaving the hospital, (3) those who continue to slowly bleed in spite of continued conservative treatment.

Control of bleeding is mandatory before irreversible damages occur. The giving of large quantities of blood, rather than offering surgery to these patients, is fraught with dangers of abnormal clotting.

Effective control of the bleeding is indicated at exploration. In the absence of a demonstrable ulcer a gastroduodenotomy should be done. Removal of the ulcer is attempted when practicable. Suture plication can be successful when followed by a definitive procedure.

Blind subtotal gastric resection has been considered but there is inadequate proof to establish its merit.

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Louis G. Welt, M.D., Chapel Hill

physician's bookshelf



Books Received

Lipman, Bernard S., M.D., and Massie, Edward, M.D., *Clinical Unipolar Electrocardiography*, (3rd ed.) The Year Book Publishers, Chicago, 1956, 397 pp.

Lippman, Hyman S., M.D., *Treatment of The Child in Emotional Conflict*, McGraw-Hill Book Company, Inc., New York, 1956, 298 pp., \$6.00.

Scharf, Robert, Ph.D., *Beware of the Three-Legged Ostrich! A Study in Best Investments* (collection of essays), Consumer Economics, Inc., Atlanta, 1956, \$1.25.

Wolstenholme, G. E. W., and O'Connor, Cecilia M., *Bone Structure and Metabolism*, Ciba Foundation Symposium, Little, Brown and Company, Boston, 1956, 229 pp., \$8.00.

Wolstenholme, G. E. W., and Miller, Elaine C. P., *Paper Electrophoresis*, Ciba Foundation Symposium, Little, Brown and Company, Boston, 1956, 224 pp., \$6.75.

Reviews

Haagensen, C. D., M.D., *DISEASES OF THE BREAST*, W. B. Saunders Company, Philadelphia, 1956, 751 pp.

The author's name speaks for itself on this subject. He has done 25 years of specialized work on diseases of the breast. He had not only his own cases, but access to all records at the Columbia-Presbyterian Medical Center in New York. From these he has drawn his conclusions.

His illustrations are well chosen, but there are a few chapters near the end of the book where the graphs are perhaps too numerous.

The chapter on anatomy stands out, as so much interest is shown today in internal mammary dissection.

One is impressed with the lack of didactic statements by the author, in spite of his vast experience. He first presents the pathologists', the radiologists', and other surgeons' views, and very fairly discusses them before summing up his ideas at the end of each chapter. The subheadings are titled in each chapter, making reference work easier.

One of the outstanding chapters is that of cystic disease.

Two-thirds of the book deals with cancer of the breast, beginning with its etiology, frequency, history, diagnosis, pathology, and ending with treatment. The material is interestingly presented and easily understood.

Since carcinoma of the breast is the most common malignancy of the female, this book is extremely practical to have. Every general surgeon should purchase this modern classic.

Charles H. Watt, Jr., M.D.

Mellan, Ibert, and Eleanor Mellan, *DICTIONARY OF POISONS*, Philosophical Library, New York, 1956, 150 pp., \$4.75.

The book is very poorly written. Grammatical and punctuation errors are often observed. The book is little more than charts that are issued and distributed by several of the pharmaceutical houses. These charts present the information along with antidotes in a much better form for the layman than this book.

The publishers infer that the volume is more for the home or layman's use, yet in the instructions for preparing many of the antidotes or emetics they state, "Dissolve a third," or a "vial," or "7.5 grains," or "half gram." How many housewives or laymen have any concept of such units of measure?

I compared this book with the chart of antidotes pasted on the back of my bathroom medicine cabinet mirror and pretty well saw the outline as followed.

My associates and I are not impressed at all by this publication. Anyone wishing such information can secure from Merck, Monsanto, or a few of the other chemical manufacturers at no cost.

Herman D. Jones, Ph.D.

Pillsbury, Donald M., M.D., Walter B. Shelley, M.D., Ph.D., and Albert M. Kligman, M.D., Ph.D., *DERMATOLOGY*, W. B. Saunders Company, Philadelphia, 1956. 1331 pp. 564 figs., \$20.00.

This book is one of the most comprehensive volumes on diseases of the skin to appear in recent years. The authors have done an excellent job in correcting many errors and misconceptions that have passed down through the years in other texts. The easy, informal manner in which the material is presented makes it an exceptionally easy book to read.

One of the more commendable features of this text is the long overdue simplification of dermatologic terminology; which in the past not only left general physicians and other specialists in a state of utter confusion, but also resulted in the dermatologist being the goat of many jokes and the victim of considerable ridicule.

There is often a great deal of controversy as to the best therapeutic approach to various disease states and this is certainly true of dermatology, perhaps more so than in other specialties. In this text the authors have attempted to weed out a great number of older therapeutic modalities that have fallen into disrepute, which is justifiable; however, there are instances in which their ideas of therapy appear highly prejudiced.

Perhaps the outstanding feature of this book is the tendency to deemphasize the use of superficial x-ray and other ionizing radiation in treating a large number of dermatoses, especially the more superficial, chronic, and recurrent dermatoses. In treatment of dermatoses of this type, Grenz ray therapy, a very soft, intermediate ionizing radiation, is advised and considered the treatment of choice when ionizing radiation is indicated. Although not without danger of complications and sequelae itself, it has a much higher index of safety.

There are several chapters included in this text that are not included as separate subjects in older texts or are lightly treated therein, such as Psycho-cutaneous Dermatoses and Industrial Dermatoses, which are being seen more and more frequently today. Especially well treated is the section on Physiology of the Skin; the authors having conducted the bulk of recent research in this field.

This book is considered a valuable text for students and as a reference for general practitioners and specialists.

Charles D. Adams, M.D.

Executive Committee of Council

November 1, 1956, Atlanta

CHAIRMAN J. W. CHAMBERS, LaGrange, called the regular monthly meeting of the Executive Committee of Council to order at 2:45 p.m., in Atlanta, Georgia.

In attendance were the following members: Hal M. Davison, Atlanta, president; W. Bruce Schaefer, Toccoa, President-elect; J. W. Chambers, LaGrange, Chairman of Council; David Henry Poer, Atlanta (by conference phone), secretary-treasurer; George R. Dillinger, Thomasville (by conference phone), Chairman of Finance Committee.

Also attending were Edgar Woody, Jr., Atlanta, *JMAG* Editor; Mr. M. D. Krueger, Executive Secretary, and Mr. John F. Kiser, Assistant Executive Secretary.

The minutes of the Council meeting of October 28, 1956 were reviewed and the minutes of the Executive Committee of Council meeting October 28, 1956 were read and approved with the notation that the Executive Committee of Council meeting set for November 17 at 7 p.m. was cancelled by general agreement.

Chairman Chambers called on Mr. Krueger to report the results of a poll vote on whether the Council would hold a special meeting prior to December 7 to approve the Medicare fee schedule or delegate responsibility of approval to the Executive Committee of Council. Sixteen of the 17 voting members of Council voted to delegate authority to the Executive Committee and requested that they meet on this matter prior to December 17, 1956.

UNEMPLOYMENT COMPENSATION TAX—Mr. Krueger reported for Mr. John Dunaway, Association attorney, on the results of a hearing held with Mr. Ben Strain in Atlanta at which the Association attempted to show just cause for exemption from unemployment compensation tax. Mr. Strain informed Council that it appears to him that the Association is not exempt under the present law. Mr. Dunaway requested another hearing which was to have been December 17, 1956.

HOSPITAL ADVISORY COUNCIL — Chairman Chambers called on Milford B. Hatcher, Chairman of the MAG Hospital Committee, who discussed the appointees required by law, from the Medical Association of Georgia to serve on the Hospital Advisory Council. The Executive Committee of Council appointed W. L. Pomeroy, Waycross, and Rafe Banks, Jr., of Gainesville, whose terms shall run to 1959, to replace Dr.'s Allen and McCall, whose terms expire in 1956.

HOSPITAL CARE STUDY COMMISSION—Milford B. Hatcher, MAG representative serving on the Hospital Care Study Commission, reported on the activity of that body and cited the need for indigent hospital care with tax funds; said funds to cross county lines with patient, etc. The activity of this committee was discussed, and the report was given for information only.

MILLEDGEVILLE STUDY COMMITTEE — Mr. Kiser reported on the Executive Committee's previous appointments in behalf of the MAG to the Milledgeville

Study Commission; the Executive Committee took no action on the matter.

INTERPROFESSIONAL COUNCIL—Mr. Kiser reported on the activity of the Interprofessional Council of Georgia and requested that the Executive Committee set the terms of MAG representatives previously appointed to serve on the council. It was moved, seconded, and approved that Chris J. McLoughlin should serve for a term of three years; that Maurice Arnold should serve for a term of two years; and, that John Stegeman should serve for a term of one year.

MEDICAL EDUCATION COMMITTEE — Mr. Krueger reported on the progress of the subcommittees of the Medical Education Committee and stated that the Subcommittee on Emory University School of Medicine was to meet with the appropriate authorities of the School of Medicine on November 29, 1956, and that the Medical College of Georgia Subcommittee and the Council of the Medical Association of Georgia would meet with the Board of Governors of Richmond County Medical Society, the Medical College of Georgia President and Dean, and the Administrator of the Eugene Talmadge Memorial Hospital, at 10 a.m., December 16, 1956, at the Bon Air Hotel, Augusta, Georgia. It was moved that an invitation be sent to all Richmond County Medical Society members to attend this meeting.

A.M.E.F.—Mr. Krueger reported for Ben K. Looper, Chairman of the AMEF Committee, to discuss plans for a Foundation drive in Georgia during the month of December. It was moved that approximately \$100.00 be appropriated for an AMEF all-member mailing to effect this project.

"MEDICARE," PUBLIC LAW 569 — Chairman Chambers called on Charles S. Jones, Council Fee Schedule Committee Chairman, for a report on the Fee Schedule negotiations in Washington, D. C., November 12, 1956. Dr. Jones related that he and Dr. Chambers and Colonel C. B. Meador discussed all the procedures in the Public Law 569 schedule of allowances for physicians fees. Dr. Jones pointed out that certain fees were changed during this discussion with Colonel Meador, and in behalf of the Association, Dr. Jones told Colonel Meador that these fees could not bind the Association until (1) the Council Fee Schedule Committee met to discuss these changes, and (2) the Council or its Executive Committee approved the changes.

Dr. Jones then reported on a meeting of the Council Fee Schedule Committee held November 18, 1956 as follows: "The members as individuals did not feel qualified or authorized to accept any of the Government changes on the 190 asterisk fees which they had previously determined. As to the remaining fees, committee members did not wish to accept any responsibility. After discussion, the committee felt that the fee schedule as negotiated in Washington on November 12, 1956, should be referred to either Council or the Executive Committee of Council for further action."

It was recommended that the Medical Association of Georgia fee schedule negotiated in Washington, November 12, 1956, with Colonel C. B. Meador of Team No. 3, be accepted by the Executive Committee on a provisional basis. It must be recognized that all fees in addition to the "asterisk fees" were suggested without adequate consultation with the proper com-

mittees. The Medical Association of Georgia therefore, reserves the right to recommend adjustment of any of these fees after proper study. This motion was then approved.

Mr. Krueger reported on the contract negotiations held in Washington, D. C., on November 12, 1956. He presented the contract and three copies as received from negotiating Team No. 3. After discussion of this contract and advice from Mr. Frank Shackelford, attorney, it was moved that the Executive Committee authorize Hal M. Davison, Association President, and J. W. Chambers, Chairman of Council, to sign for the Medical Association of Georgia the contract received from Team Captain No. 3 Major Andrew L. Cappy, subject to the following changes in the contract—(i) professional claim rate of \$2.75, and (ii) the addition of \$1,500.00 per annum for typists as needed; and subject to these changes in the estimated allowable cost sheet as amended during negotiations in Washington and furnished to the contracting officer (i) \$50.00 per day or portion of a day to members of the Review Board meeting as required; 75.00; and (ii) legal counsel, \$2,400.00. This motion was approved.

JMAG PHOTOS—Edgar Woody, Jr., Editor of the *Journal of the Medical Association of Georgia*, submitted a proposal to the Executive Committee of Council for the purchase of a Polaroid Land Camera or its equivalent to facilitate taking pictures at county society and district meetings and printing such pictures in the *JMAG*. Dr. Woody expressed his opinion that this would add a great deal to the readability of the *Journal* and that the purchase of such an item would run at approximately \$100.00. It was recommended that this purchase be approved if the Finance Committee finds funds available. This motion was approved.

Chairman Chambers then called for unfinished business, and there being none, he called for new business. Dr. Schaefer asked that the Headquarters Office write a letter to the secretary of each county medical society concerning information about the use of radioactive isotopes in their respective counties by physician members. Dr. Schaefer agreed to draft this letter and forward it to the Headquarters Office for transmittal to the secretaries of the component county medical societies. This request was approved.

There being no further business, the meeting adjourned at 5:25 p.m.

Insurance and Economics Committee

November 25, 1956, Atlanta

CHAIRMAN DAVID R. THOMAS, JR., called the meeting to order at 10:30 a.m., November 1, 1956, in the Academy of Medicine, Atlanta, Georgia.

Members of the Insurance and Economics Committee present included: David R. Thomas, Jr., Augusta, chairman; Rudolph Bell, Thomasville; Thomas E. Floyd, Griffin; Charles S. Jones, Atlanta, co-chairman; Herbert M. Olnick, Macon; D. Lloyd Wood, Dalton; W. L. Pomeroy, Waycross; W. Perrin Nicolson, III, Gainesville, and Harry D. Pinson, Augusta. Members of the Health Insurance Council present included: Mr. Bert Whitehall, New York City; Mr. R. J. Jones, Greensboro, N. C.; Mr. Lam Schulze, Chattanooga, Tenn.; Mr. Price Cross, Rome; Mr. Lee Laney, Atlanta; Mr. Wil-

liam F. Hawkins, Atlanta; Mr. T. L. Blalock, Waycross; and Mr. LaFayette Davis, Atlanta. Executive Secretary Mr. M. D. Krueger was also present.

Chairman Thomas called for the minutes of the Insurance and Economics Committee meeting held April 29, 1956. A correction concerning reprinting of the blue book (page 3, paragraph 7) was made in that Mr. Schulze was authorized to design the cover for the new revised Georgia Plan booklet. It was also brought to the attention of the Board by Mr. LaFayette Davis that he had not been told about a card for representatives of insurance companies handling MAG approved insurance. That part of the April 2, 1956, minutes was re-read for clarification as follows: "A motion (Jones-Pinson) that the wording on this card be as follows: 'This is to introduce Mr. _____ of _____ company, who is writing _____ coverage as approved by the Medical Association of Georgia.' This motion was approved." The minutes were approved as corrected.

Social Security Coverage (OASI Title II)—Charles S. Jones led a discussion on the principles and practices involved in the consideration of inclusion of physicians under the present social security laws. He read the AMA Board of Trustees' statement as carried in the *JAMA* and also discussed results of an investigation conducted at the request of Chairman Thomas. It was moved that the Insurance and Economics Committee recommend to the MAG Council that the membership of the Medical Association of Georgia be included under the present Social Security Program, OASI Title II. This motion was unanimously approved, with the request that it be written into the minutes that approval was given reluctantly on the principles involved in the present social security program. It was moved that the MAG make a concerted effort to disseminate factual information to the MAG membership on the present social security program (OASI Title II).

It was moved that the Chairman of the Insurance Board appoint a committee of two board members to prepare this material for dissemination by the December 15-16 MAG Council meeting, and these two members submit this material. Chairman Thomas appointed Dr.'s Jones and Pomeroy.

Professional Liability Program—Mr. Krueger presented a brief report on the progress of the MAG-St. Paul Mercury Insurance Company professional liability program. It was moved that the Insurance and Economics Committee of the Medical Association of Georgia heartily endorse and approve the initiation of a 10-minute film presentation on professional liability problems of physicians as an educational device for use by the county medical societies in Georgia, and it was further moved that this information be transmitted to the St. Paul Mercury Insurance Company for their information.

Overhead (Office Expense) Insurance—Presentations on "overhead insurance" plans for physician's office expense coverage were presented to the committee. The committee made no recommendation and took no action on these plans as it was felt that this type of insurance is available already on an individual basis and there was no need for a group program at this time. It was moved that a short article be put in the *Journal of the Medical Association of Georgia* explaining "overhead insurance" so that the membership might

be aware of the advantages and disadvantages of this type of coverage. This motion was approved.

Comprehensive and Major Medical Insurance — Chairman Thomas led a discussion on the growth and progress of both comprehensive and major medical insurance. Mr. Schulze distinguished between the principles of comprehensive health insurance coverage and major medical coverage and the board requested further information on these types of insurance. Mr. Bert Whitehall of the Health Insurance Institute said he would be responsible for distributing to committee members more data.

Georgia Plan Problems — Mr. Krueger presented three major problems in connection with the implementation of the revised Georgia Plan:

(1) **MAG Physicians Participation**—To increase physician participation it was recommended and generally agreed that the improvements in the revision should be emphasized to all physicians in another all-member mailing; that the secretaries of the county societies be asked to personally contact the members of their societies to gain further participation of the membership; that the Insurance and Economics Committee members influence the county society secretaries to emphasize the need for participation to the membership; and that the *Journal of the Medical Association of Georgia* carry informative articles promoting further doctor participation in the Georgia Plan.

(2) **Insurance Company Participation**—To speed up and effect more insurance company participation, Mr. Whitehall, of the Health Insurance Institute, was asked to remind all companies of the opportunity and advantages of writing the Georgia Plan; and to have the Headquarters Office mail a letter to the companies not yet heard from reminding them of the advantages of writing the revised Georgia Plan.

(3) **Medical, Insurance and Legal Advice to Expedite Georgia Plan Policy Decisions**—It was recommended that the Headquarters Office refer contractual problems in connection with the revised Georgia plan to Dr. Thomas if these matters are of a medical nature; to Chairman of the Health Insurance Council, Mr. R. J. Jones, if these matters are of an insurance nature; and to Mr. Dunaway if the matters are of a legal nature.

Other specific matters of policy decision were brought to the attention of the Insurance and Economics Committee by Mr. Krueger; it was decided to ask the Health Insurance Council to inform insurance companies about the mandatory writing of the in-hospital and anesthesia benefits in the revised Georgia Plan.

The chairman then called for unfinished business. Mr. Whitehall was requested to let the Insurance and Economics Committee know about the progress of the insurance form standardization of claim forms undertaken by Mr. Richard Eales.

By general agreement, the Insurance and Economics Committee had no objection to the use of envelopes with the Medical Association of Georgia return address on the approved Provident Life Insurance program handled by Mr. LaFayette Davis.

As brought to the committee's attention, the advertising in the *Journal of the Medical Association of Georgia*, date of August, 1956, page 345A, was recommended as not being acceptable to the committee in

that the wording in said advertisement's headline misleads Georgia physicians into believing this program has been endorsed by the Association. The Insurance and Economics Committee, realizing its limited jurisdiction in this matter, wished to bring this to the attention of the *JMAG* Editor, Edgar Woody, Jr., so that he may be informed of the Insurance Board's recommendation on the matter.

The Chairman called for new business, and there being none the meeting was adjourned at 3:30 p.m.

Report of Mental Health Conference

THE CHAIRMAN OF THE MAG Mental Health Committee attended this conference as the representative of the Medical Association of Georgia. The conference was organized by the Council on Mental Health of the American Medical Association and was primarily concerned with the discussion of four topics. The conference representatives were organized in four discussion groups with one topic assigned to each group. The reports from each discussion group were brought back to the full conference for final discussion and recommendations.

The topics discussed were: (1) "The Use of Hypnosis in Medical Practice"; (2) "The Alcoholic Patient as a Medical and Hospital Management Problem"; (3) "Benefits and Problems Encountered by General Practitioner with Use of Newer Tranquilizing Drugs for Patients with Emotional Illness"; and (4) "Inpatient Psychiatric Care for Children." Each of these topics can be applied to problems existing in our own state, and the reports of these discussion groups will be circulated to members of our Mental Health Committee with full consideration being given to including these ideas in the activities of the committee and the Medical Association.

This type of meeting presented to me an opportunity to discuss with representatives from the American Medical Association and from other state medical associations the activities of our Mental Health Committee and possible direction for further activities within our association.

It seems clear that these annual conferences provide an excellent opportunity for coordination of mental health activities amongst the state medical associations and reflect the intention and determination of the American Medical Association to encourage physicians throughout the country to provide leadership in all phases of mental health. The American Medical Association recognizes full well that the nation's number one health problem at this time is reflected in the fact that over half of all hospital beds are occupied by patients suffering with mental illness. There were representatives at this meeting from the Women's Auxiliary to the American Medical Association, and it is the intention of the Auxiliary to promote mental health as one of its key activities during this coming year. We all realize that we have only begun to scratch the surface of knowledge needed to effectively combat and prevent mental illness, but we realize at the same time that present activities indicate that the medical profession and the nation are on the verge of broad and far-reaching efforts to apply the knowledge already available to the problems presently confronting us.

Rives Chalmers, M.D.

INFORMATION

ANNOUNCEMENTS

Meeting Calendar

American Medical Association—June 3-7, 1957, The Coliseum, New York City.

American College of Physicians—April 8-12, 1957, Boston, Mass.

American College of Surgeons Regional Meeting—February 4-7, 1957, Roosevelt Hotel, New Orleans, La.

Medical Association of Georgia—April 28-May 1, 1957, DeSoto Hotel, Savannah.

Georgia Society of Anesthesiologists—April 21-24, 1957, Savannah.

Georgia Diabetes Association—April 28-May 1, 1957, DeSoto Hotel, Savannah.

Georgia Society of Ophthalmology and Otolaryngology—May 18-23, 1957, aboard S. S. Silverstar from Charleston, S. C.

Georgia Psychiatric Association—February 18, 1957, Atlanta.

Georgia Urological Association—April 28-May 1, 1957, DeSoto Hotel, Savannah.

Georgia Industrial Surgeons Association—April 28-May 1, 1957, DeSoto Hotel, Savannah.

Atlanta Graduate Assembly—February 18-20, 1957, Atlanta.

American College of Physicians 1957 Annual Session—April 8-12, 1957, Boston. For information write to Dr. Richard P. Stetson, 203 Commonwealth Ave., Boston 16, Mass.

American Congress of Physical Medicine and Rehabilitation—35th annual scientific and clinical session, September 8-13, 1957, Hotel Statler, Los Angeles, Calif. For information, write to the Executive Secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Ave., Chicago 2, Ill.

Annual Prize Lecture, American Congress of Physical Medicine and Rehabilitation—Manuscripts must be submitted by June 1, 1957. Contest open to medical students, interns, residents, graduate students in the pre-clinical sciences, and graduate students in physical medicine and rehabilitation. For information write to the American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Ave., Chicago 2, Ill.

1957 Mississippi Valley Medical

Society Essay Contest—Any subject of general medical or surgical interest including medical economics and education may be submitted by physicians who are members of the A.M.A. and are residents and citizens of the U. S. Cash prize—\$100; gold medal and certificate given. Essays must be submitted by May 1, 1957. Further details may be secured from Harold Swanberg, M.D., Secretary MVMS, 209-224 W. C. U. Building, Quincy, Ill.

American College of Surgeons Sectional Meeting—February 4-7, 1957, Hotels Roosevelt and Jung, New Orleans, La. Program will include panel discussions, symposia, scientific papers, cine clinic films on general surgery, and separate programs in the specialties of urology, ophthalmology, ob-gyn, otolaryngology, thoracic surgery, and orthopedic surgery. There will also be a joint nurses' program. For more information, write to the American College of Surgeons, 40 East Erie St., Chicago 11, Ill.

American College of Surgeons Intensive Course on Fractures and Other Trauma—April 10 to 13, 1957, John B. Murphy Auditorium, 50 East Erie St., Chicago. Lectures and demonstrations will be conducted by surgeon-teachers of the Chicago area. Clinical cases will be presented, and discussion and questions from the floor are invited. For further information write to John J. Fahey, M.D., 1791 West Howard St., Chicago, Ill.

Harvey Tercentenary Congress—June 3-7, 1957, Royal College of Surgeons, London, England. The theme will be "A Review of the Present Knowledge of the Circulation." Topics will include the following: "Knowledge of the Circulation from the 17th-20th Centuries," "The Role of the Heart in the Circulation," "The Results of Cardiac Surgery," "The Coronary Circulation," "The Pulmonary Circulation," etc. For further details and application for membership write to the Congress Secretary, 11 Chandos St., Cavendish Square, London, W. L.

First Pan American Cancer Cytology Congress—April 25-29, Miami Beach, Fla. Twenty-one nations of the Western Hemisphere are invited

to attend the congress which is sponsored by the Southern Society of Cancer Cytology, the Cancer Institute at Miami, the Univ. of Miami, and the Cancer Cytology Foundation of America, Inc., New York. Physicians wishing to present scientific papers at the Congress should apply to Program Chairman, Dr. Wayne Rogers, P. O. Box 633, Coral Gables, Fla. Inquiries relative to scientific exhibits or motion picture presentations should be sent to Dr. Homer L. Pearson, P. O. Box 633, Coral Gables, Fla. Two awards of \$1,000 each will be presented to the two scientists presenting papers whose work is judged to represent "outstanding research in cancer cytology."

53rd Annual Congress on Medical Education and Licensure—February 10-12, 1957, Palmer House, Chicago, Ill. Meeting will be sponsored by AMA's Council on Medical Education and Hospitals, the Federation of State Medical Boards of the U. S., and the Advisory Board of Medical Specialties.

Fourth Interim Congress of the Pan American Association of Ophthalmology*—April 7-10, 1957, Hotel Statler, New York, N. Y. The National Society for the Prevention of Blindness will meet at the same time. All ophthalmologists in good standing are invited to the Congress. Hotel reservations should be made direct with the Hotel Statler, New York.

Institute on Rehabilitation Center Planning—February 25-March 1, 1957, Morrison Hotel, Chicago, Ill. Open to all persons interested in the establishment, expansion, or improvement of comprehensive rehabilitation facilities; the institute is being conducted by the Conference of Rehabilitation Centers, Inc., under a training contract with the U. S. Office of Vocational Rehabilitation. Inquiries concerning the Institute should be addressed to the Division of Special Projects, Conference of Rehabilitation Centers, Inc., 5 Franklin Ave., Saranac Lake, New York.

Oak Ridge Institute of Nuclear Studies, Seminars on Thyroid-Uptake Measurement—March 18-19, 1957, and April 15-16, 1957. Two seminars open to those who have not participated in the thyroid-uptake calibration survey. Fee: \$25.00. Proposed program includes the fol-

(Announcements)

lowing sessions: The Phantom, The Formula, The Standard, The Spectrum, Other Parameters of Variation, Summary. Applications are available from William C. Busby, Oak Ridge Institute of Nuclear Studies, Medical Division, Box 117, Oak Ridge, Tenn.

DEATHS

Resolution

In the passing of DR. CHARLES HALL FARMER on June 23, 1956, the Bibb County Medical Society has suffered a great loss. He was loved and respected by all who knew him, and was a faithful member of this society. The Bibb County Medical Society wishes to express its deepest sorrow over his passing and extends its heartfelt sympathy to his family and friends.

Henry H. Tift, M.D.

Thomas L. Ross, M.D.

CHARLES E. BOYNTON, Atlanta, died on November 22, 1956, at the home of his daughter in Atlanta. He was 84 years old.

A native of Atlanta, Dr. Boynton was a graduate of Boys High School and Princeton University. Dr. Boynton received his medical education at the College of Physicians and Surgeons. Dr. Boynton served as a doctor aboard a naval hospital ship during the Spanish American War.

He returned to Atlanta after the war to practice pediatrics for 50 years. He was an active member of Trinity Methodist Church and a fellow of the American College of Physicians and the Academy of Pediatrics.

Survivors include his daughters, Mrs. James R. Brown, Ponta Vedra Beach, Fla., and Estelle Boynton, M.D., Atlanta; a sister, Mrs. Newton Craig, Atlanta, and six grandchildren.

Funeral services were held on November 24, 1956, at Spring Hill Chapel; burial was in Westview Cemetery. Acting as pallbearers were Floyd McRae, J. K. Fancher, Jeff L. Richardson, George Klugh, A. I. Miller, Hal M. Davison, Hugh Lokey, Sr., William Perrin Nicolson, Jr., Marshall Sims, and Don F. Cathcart, all of Atlanta.

LOUIS M. HAWKINS, Blackshear, died on November 16, 1956, at the age of 72. He had been ill for quite some time.

Dr. Hawkins, a native of Warwick, graduated from the Emory University School of Medicine in 1909 and began practicing in Americus. He moved to Blackshear in 1920 where he practiced until his retirement a few years ago.

He was a member of the Ware County Medical Society, a Mason and a faithful member of the First Baptist Church of Blackshear. For many years he served on the board of deacons and was honorary chairman of the board at the time of his death. He was a former member of the Blackshear Rotary Club and Kappa Psi Medical fraternity. He was also a past chairman of the Sumter County Board of Education.

Surviving Dr. Hawkins are his wife, the former Miss Sarah Daniel; a daughter, Miss Florence Hawkins, Vidalia; one son, Louis M. Hawkins, Jr., Ludowici; a sister and a brother.

Funeral services were held November 18th at the First Baptist Church. Among the pallbearers were the following physicians: G. T. Hendry, W. F. Reavis, L. C. Durrence, A. M. Knight, Jr., Lovick Pierce, T. J. Ferrell, D. M. Bradley, all of LaGrange.

ROY W. MCGEE, Atlanta, died on November 29th. Dr. McGee was for many years head of the Fulton County Health Department and had announced his retirement only a short time before his death; it was to have become effective December 19th.

Dr. McGee received his medical degree from Emory University School of Medicine in 1912 and practiced medicine in Ben Hill community before entering public health work with Fulton County in 1921. He became commissioner of health, or head of the County Health Department in 1928. He obtained his master's degree in Public Health Administration from the University of Michigan in 1940.

He was a member of the Fulton County Medical Society, Georgia Public Health Association, and the American Public Health Association. He also was a member of the Cascade Methodist Church, a Mason, and a member of the Order of Eastern Star.

Dr. McGee is survived by his wife and two daughters, Mrs. J. E. Marlow and Mrs. J. C. Wood, both of Atlanta.

SOCIETIES

The FLOYD COUNTY MEDICAL SOCIETY met November 20, 1956, at the Greystone Hotel. After a dinner and social hour, Medical Association of Georgia President Hal M. Davison, discussed certain aspects of medical education, both of the Medical College of Georgia and the Emory University Hospital, and the status of the practice of medicine in these areas. Dr. Davison reported on the Council's activity and the MAG Medical Education Committee's plans in connection with this problem. Dr. Davison also discussed the prevention of professional liability claims and endorsed the MAG St. Paul Mercury professional liability program. Executive Secretary of the Association, Mr. M. D. Krueger, discussed Medicare, Public Law 569, the Georgia Plan, the Association's forthcoming state meeting to be held April 28-May 1, DeSoto Hotel, Savannah, and the delegates' duties at that meeting in representing Floyd County Society.

In the Floyd County Medical Society business meeting, the following officers for 1957 were elected: president-elect, Sam Garner, Rome; secretary-treasurer, John D. Tate, Rome; delegate to the MAG, Stephen D. Smith, Rome; alternate delegate, C. J. Wyatt, Jr.; delegate, Ralph Johnson, Rome; alternate delegate, Lester Martens; delegate, A. V. Gafford, Rome; alternate delegate, R. F. Corpe, Rome.

At the November meeting of the GEORGIA MEDICAL SOCIETY Meredith F. Campbell, emeritus professor of urology of New York University and lecturer in urology at the University of Miami Medical School, spoke on "Common Urologic Conditions in Infants and Children."

The MUSCOGEE COUNTY MEDICAL SOCIETY met on November 27, 1956, to elect officers for 1957. Clarence C. Butler assumed the office of president, and Henry H. Boyter was named president-elect. George L. Epps is a new member of the Board of Censors, which also includes Franklin D. Edwards and Luther H. Wolff. Robert H. Vaughan is secretary-treasurer of the society, serving a three-year term which expires in 1957. The meeting was a dinner meeting held at the Standard Club, Columbus.

(Societies)

SOUTHWEST GEORGIA MEDICAL SOCIETY held its annual meeting in November and elected the following officers: president, J. G. Standifer, Blakely; vice-president, H. J. Merritt, Colquitt; secretary-treasurer, H. P. Wood, Fort Gaines; delegate, T. W. Rentz, Colquitt; alternate, R. B. Quattlebaum, Fort Gaines; board of censors, 1957, J. H. Crowdis, Blakely; 1958, H. L. Morgan, Arlington; 1959, J. B. Martin, Edison.

THOMAS-BROOKS MEDICAL SOCIETY held its annual Christmas meeting on December 13, 1956. The scientific meeting was held in the John D. Archbold Memorial Hospital; appearing on the program were W. L. Fitzgerald, Miami, Fla., "Factors Contributing to Recurring Kidney Stones;" and James H. Ferguson, Miami, "Management of Hemorrhage in Late Pregnancy." Following the scientific session the society had a social hour, dinner and dance at the Glen Arven Country Club.

Hal M. Davison, president of the MAG, was the guest speaker at the November meeting of the **TRI COUNTY MEDICAL SOCIETY**.

Members of the **WALKER-CATOOSA-DADE MEDICAL SOCIETY** were entertained at dinner on October 30th by Dr. and Mrs. Charles Stephenson at their home in Ringgold. After dinner a business meeting was held.

PERSONALS

Fourteen Georgia physicians presented scientific papers at the 50th Anniversary Meeting of the Southern Medical Association, November 12-15, 1956, in Washington. They are as follows: **EDGAR BOLING**, Atlanta; **ALBERT A. BRUST**, **JOHN R. McCAIN**, **J. HIRAM KITE**, **F. J. FUNK**, **J. D. MARTIN, JR.**, **HELEN A. MOORE**, **MILTON F. BRYANT, JR.**, **JAMES A. KAUFMANN**, **MAJOR FOWLER**, and **ARTHUR R. EVANS**, all of Atlanta; **JOHN K. BURNS**, Gainesville; **ROBERT L. BENNETT**, Warm Springs, and **J. ROBERT RINKER**, Augusta. Taking part in discussions were **PERRY P. VOLPITTO**, Augusta; **WILLIAM L. DOBES**, **JOHN H. RIDLEY**, **OSLER A. ABBOTT**, **HARRIET E. GILLETTE**, and **EARL RASMUSSEN, JR.**, all of Atlanta. **JACK C.**

NORRIS, Atlanta, is the councilor to the Southern Medical Association from Georgia; **HERBERT ALDEN**, Atlanta, is vice-chairman of the section on dermatology and syphilology; **TED F. LEIGH**, Emory University, is secretary of the radiology section. **JOSEPH S. CRUISE**, Atlanta, is second vice-president of the Southern Chapter, American College of Chest Physicians; and **CHARLES RIESER**, Atlanta, is a member of the association's editorial board. "Radiologic Study of Diseases of the Larynx and Pharynx" was the subject of an exhibit presented by **BRIT B. GAY, JR.**, and **JOSEPH CHANG**, Emory University, which won honorable mention. Other Georgia physicians presented exhibits at the meeting: **MURDOCK EQUEN**, **GEORGE ROACH**, **ROBERT BROWN**, and **TRUETT BENNETT**, Atlanta, presented an exhibit on cancer of the larynx; **W. S. FLANAGIN**, Augusta, presented an exhibit on "Plastic Surgery for Defects of the Mid-Face."

At the Sectional Meeting of the American College of Surgeons to be held in New Orleans, February 4-7, 1957, the following Georgia physicians will present papers: **J. ELLIOTT SCARBOROUGH**, Emory University—"Tumors of the Salivary Glands;" **JOHN HOWARD**, Emory University—"Fluid Balance and Electrolytes" (panel discussion); **OSLER A. ABBOTT** and **WILLIAM H. GALVIN**, Emory University—"The Health Team in Action in Surgery of the Lung" (panel discussion); **C. E. IRWIN**, Warm Springs—"Paralytic Scoliosis;" **J. MASON BAIRD**, Emory University—"Recent Advances in Cataract Surgery;" and **SAMUEL A. WILKINS**, Emory University—"Evaluation of Treatment Failures in Patients With Cancer."

First District

Four Savannah physicians attended the meeting of the Seaboard Railway Surgeons Association in New Orleans, November 26-29, 1956. They are **T. A. PETERSON**, **R. L. NEVILLE**, **W. W. BUCKHAULTS**, and **J. K. QUATTLEBAUM**.

ELLISON R. COOK, III, Savannah, was guest speaker at a recent meeting of the Statesboro Senior Woman's Club. He showed the film, "Valiant Heart," and commented on

it and the danger of rheumatic fever in the lives of children.

T. A. PETERSON, Savannah, was the speaker at a "Boss Night" dinner of the Azalea Chapter, American Business Women's Association.

PETER L. SCARDINO, Savannah, has been elected president of the medical staff of St. Joseph's Hospital in Savannah. Other officers elected in November were **A. H. CENTER**, vice-president; **DEARING A. NASH**, secretary; and **W. LAWRENCE SALTER**, treasurer. **THOMAS A. McGOLDRICK** and **M. M. SCHNEIDER** have been elected to the board of governors of the hospital; **M. J. EGAN** and **J. HARRY DUNCAN** are the other two members of the board.

R. L. SCHLEY, JR., Savannah, division surgeon of the 48th Armored Division, Georgia National Guard, has been promoted to the rank of colonel. Dr. Schley is the first National Guard officer to be advanced to a colonelcy in Savannah since 1948. He entered the army as a lieutenant in 1943 and served as battalion surgeon with the 1st Battalion, 260th Infantry in the Rhineland and Central European Campaigns. He later served as commanding officer and chief of the medical service at the hospital at Fort Bragg. Dr. Schley has been connected with the 48th Armored Division for the past five years.

IRVING VICTOR, Savannah, has been awarded a traveling fellowship by the Southeastern Section, American Urological Association. Dr. Victor and two other physicians from the Southeast will spend one week in January with **W. W. Scott** at Johns Hopkins and another week at Wesley Memorial Hospital, Chicago, with **Vincent J. O'Connor**. They will make their formal report at the March meeting of the Southeastern Section of the American Urological Association to be held in Atlanta.

Second District

A. W. DeLOACH, Cairo, has returned to Cairo to practice medicine and surgery after having spent two years in Saudi Arabia. He has opened offices in the Nicholson Apartments on North Broad Street. Dr. DeLoach spoke at a recent meeting of the Cairo Kiwanis Club on the situation in the Near East

(Personals)

and the crisis centering around the Suez Canal.

FRANK LITTLE, Thomasville, was the guest speaker at a recent meeting of the Thomasville Rotary Club. He was presented by JOHN T. KING, Thomasville. Dr. Little spoke on the development of anesthesia.

Third District

CLARENCE C. BUTLER, Columbus, spoke at a recent meeting of the Sertoma Club on behalf of the Muscogee County Medical Society in the current diabetes drive.

C. C. Goss, Ashburn, has returned to Ashburn to resume his medical practice with the Goss Clinic. Dr. Goss left Ashburn on May 15th to accept a position with the Veterans' Administration in Atlanta. He and his family have made their home in McDonough. Dr. Goss is again in practice in Ashburn with WOODROW GOSS and JAMES REYNOLDS, and he expects to remain there permanently.

JACK W. HIRSCH, Columbus, spoke to the Columbus Exchange Club on "Diabetes Detection" in November.

Royce Hobby, Ashburn, has opened offices in Ashburn for the general practice of medicine in the Rose Building on Main Street. Dr. Hobby was discharged from the U.S. Air Force on October 31, 1956; he was last stationed in Newfoundland. Dr. Hobby is a graduate of Emory University and the Emory University School of Medicine. He interned and served one year of surgical residency at the Medical College of Virginia Hospital in Richmond before entering service in 1954.

LEONARD MAHOLICK, Columbus, medical director of the Bradley Center, spoke to the Rotary Club on "The Three Ring Community Crisis—What We Can Do About It." He cited the need for various community agencies to work together in attacking major community problems of maladjustment, ill health, and dependency.

J. C. PATTERSON, Cuthbert, talked on the use of the x-ray in diagnosis of diseases at a meeting of the Cuthbert Rotary Club recently.

EDWARD STOREY, Columbus,

told Rotary members in Columbus how the diabetes detection drive was carried out. The Muscogee County Medical Society put on a real campaign to inform the general public about the drive and free tests given by society members to help in the detection of diabetes. HAYWOOD TURNER was the guest speaker at a Lions' Club meeting in this same effort.

Fourth District

ENOCH CALLAWAY, LaGrange, got the Troup County Negro Cancer Drive underway at a meeting held in LaGrange on November 13, 1956. He spoke to a group of 50 at a meeting of the Negro division of the Troup County Chapter, American Cancer Society. Dr. Callaway is a director of the American Cancer Society and the West Georgia Cancer Clinic.

A. P. Duff, Hogansville, has opened his office in the Burden Building on East Main Street for the general practice of medicine. Dr. Duff comes to Hogansville from Greenville, S. C., where he has practiced since 1948. He is a graduate of the Medical College of Georgia.

BEN H. JENKINS, Newnan, has been elected to membership in the New York Academy of Sciences.

E. Descombe Wells, Jr., LaGrange, has opened offices in LaGrange for the practice of surgery it has been announced. Dr. Wells is a native of Savannah, a graduate of Clemson College and the Medical College of Georgia. He served his internship and surgical residency at Jefferson Hospital in Birmingham. He had further training at the College of Physicians and Surgeons of Columbia University and Oteen Veterans Administration Hospital in North Carolina. Dr. Wells is a diplomate of the American Board of Surgery. Dr. Wells' new office is located at 301 North Lewis Street in LaGrange.

Fifth District

DONALD S. BICKERS, Atlanta, recently attended the meeting of the Southern EEG Society in Nashville, Tenn., and presented two papers: "EEG Observations in Conscious and Anesthetized Subjects Under Controlled Respiration" and "The EEG in Neurosurgery." Dr. Bickers also attended the meeting of the

Congress of Neurological Surgeons in Chicago in November.

LEWIS B. HASTY, East Point, is now associated with W. W. COPPEDGE, East Point, in the practice of obstetrics and gynecology. A native of Roanoke, N. C., Dr. Hasty received his B.S. degree from the University of Richmond in 1947 and was graduated from the Medical College of Virginia in 1951. He took his residency training at Crawford W. Long Memorial Hospital and Grady Memorial Hospital in Atlanta. Dr. Hasty resides with his wife and two children, Jeff and Jenny, at 2468 Plantation Drive, East Point.

J. WILLIS HURST, Emory University, gave the Gainesville Rotarians a layman's outline of heart disease, cautioning against self-diagnosis, at a recent meeting. Dr. Hurst was introduced by RAFF BANKS, JR., Gainesville. Dr. Hurst is assistant professor of cardiology at the Emory University School of Medicine.

J. H. KITE, Atlanta, was the principal speaker at a meeting of the Scottish Rite bodies of Savannah. Dr. Kite is head of the Scottish Rite Hospital for Crippled Children in Decatur, and is also a 33rd degree Mason. Dr. Kite discussed the treatment offered by the hospital and showed films taken at the hospital.

DR. and MRS. A. H. LETTON, Atlanta, spent a week in December in Sarasota, Fla., where Dr. Letton took part in the Sarasota Graduate Study. In November, Dr. Letton was made an honorary member of the Mississippi Valley Medical Society.

J. D. MARTIN, JR., Emory University, was guest speaker at a meeting held at Fort Rucker, Ala., at which doctors from Georgia, Alabama, and Florida gathered. Dr. Martin discussed "Multiple Intra-abdominal Injuries." The dinner meeting, an annual affair sponsored by Fort Rucker medical personnel, was held in the hospital dining room. More than 100 doctors attended.

The members of Baron DeKalb Chapter, Daughters of the American Revolution, met on November 23rd in Decatur to hear JOHN R. McCAIN, Atlanta, discuss "Socialized Medicine."

At the November meeting of the

(Personals)

Georgia Chapter of the National Nephrosis Foundation held in Atlanta. ARTHUR J. MERRILL, Atlanta, spoke on Nephrosis and answered questions from the audience following the showing of a film entitled, "Children with Nephrosis."

Miss Eileen Patricia Thurston was married to PETER A. OLIVA, Atlanta, on Saturday, November 3, 1956, at the Sacred Heart Church, Atlanta. The bride is on the nursing staff of St. Joseph's Infirmary and Dr. Oliva is associated in practice with J. KELVIN BLEICH in the Doctors' Building. They are residing at 1111 Virginia Avenue, N. E.

Tom D. Raaen, Atlanta, has assumed the duties of chief pathologist of Grady Memorial Hospital in Atlanta. Before coming to Atlanta, Dr. Raaen was chief of the clinical laboratory and pathology service at the 2750th USAF Hospital, Wright-Patterson Air Force Base, Ohio. A native of Brooklyn, Dr. Raaen is a graduate of the Medical College of New York University; he is a member of the American College of Pathologists.

Sixth District

FRED COLEMAN, Dublin, has been sworn in by Governor Marvin Griffin for another six-year term on the State Board of Medical Examiners.

DR. and MRS. E. Y. WALKER, Milledgeville, attended the joint meeting of the Georgia Society of Obstetrics and Gynecology and the Alabama Association of Obstetricians and Gynecologists held in Columbus in November. Dr. Walker participated in a panel discussion at the meeting.

Seventh District

LESTER MARTENS, Rome, is now physician for the General Electric Company in Rome.

J. J. NUTT, Bowdon, celebrated his 69th birthday anniversary and 42nd year of medical practice in November, and on that occasion people came from miles around to pay tribute to the venerable physician. There was a morning service at the community clubhouse, basket lunch and an afternoon program, all sponsored by the citizens of Veal Community. Other physicians on hand for the celebration were D. S. REESE and O. W. ROBERTS, Car-

rollton, and W. P. SMITH, Bowdon. Dr. Nutt was born in Heard County and attended school at Centralhat-
chee, Glenloch, and Bowdon before entering Emory University School of Medicine, from which he was graduated in 1914. He is married to the former Miss Margaret Sumlin.

Eighth District

DR. and MRS. E. ADAMS DANEMAN have moved to Jesup for residence, and Dr. Daneman has opened offices in Waycross and St. Simons. A graduate of Kenyon College in Ohio, Dr. Daneman received his M.D. from the University of Cincinnati and interned at Jewish Hospital in Cincinnati. He served as resident in pathology at Emory University Hospital and had graduate training in psychiatry at Foxboro State Hospital, Foxboro, Mass. and at Worcester (Mass.) State Hospital. He has served on the staffs of Tufts University College of Medicine and the Worcester City Hospital Psychosomatic Clinic.

Ninth District

William T. Ariail, Cornelia, announces the opening of his office at 23 Clarkesville Street for the practice of general medicine and obstetrics. Dr. Ariail is a native of Cornelia and a graduate in pharmacology of the University of Georgia. He served with the U. S. Army Medical Corps during World War II. He was a practicing pharmacist for some years before entering graduate school at the University of Florida where he received his master's degree in pharmacology in 1951. He then entered the Medical College of Georgia and received his M.D. degree from that institution. He interned at Greenville (S. C.) General Hospital. For the five months before coming to Cornelia, he was resident physician in obstetrics and gynecology at Georgia Baptist Hospital in Atlanta.

Houston W. Kitchens, Snellville, has opened his office for the practice of medicine in Snellville. He lives and has his offices in the residence-clinic built by the people of Snellville. Dr. Kitchens is a graduate of the University of North Carolina and has a B.S. degree in pharmacology from Alabama Polytechnic Institute. He received his M.D. degree from Emory University School of Medicine and

served his internship and residency at Emory University Hospital.

Tenth District

HARRY L. CHEVES, Union Point, has been asked to meet with the faculty of the Medical College of Georgia at their regularly scheduled conferences and to work with HARRY O'REAR, Dean of the medical school, on a preceptorship program wherein medical students will spend six weeks of their training program with a general practitioner.

ROBERT B. GREENBLATT, Augusta, attended the board meeting of the American College of Obstetricians and Gynecologists in Chicago in November. He served as a leader of the round table discussion on Gynecologic Endocrinology. He was a guest speaker at the Pacific Coast Society for the Study of Sterility.

RUFUS F. PAYNE, Augusta, read a paper on "Isoniazid in Therapy and Prevention of Tuberculosis" before the American Public Health Association convention held in Atlantic City in November.

CAROL G. PRYOR, Augusta, has recently returned from Chicago where she was inducted as a fellow into the American College of Obstetricians and Gynecologists. In October, she became a fellow of the American College of Surgeons.

ERNEST THOMPSON, formerly of Monroe, has assumed his duties as Cobb County Health Commissioner, as of January 1, 1957. Dr. Thompson was formerly Walton County Health Commissioner.

PERRY P. VOLPITTO, presented a paper before the post-graduate assembly of the New York State Society of Anesthesiologists, which was held December 6-8, 1956, in New York. His paper was entitled, "Trends in Undergraduate and Graduate Education in Anesthesiology."

A. CALHOUN WITHAM, Augusta, assistant professor of medicine of the Medical College of Georgia, has been awarded a \$25,000 training grant from the National Heart Institute. The grant covers the period November 1, 1956, through October 31, 1957, and will assist in providing personnel and equipment for cardiovascular research and teaching at the Medical

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyrighted, 1957, by the Medical Association of Georgia, 875 West Peachtree Street, N.E., Atlanta 9, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; \$1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.

Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

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COVER

Pictured in this photo by Ted F. Leigh, M.D., is the inside of the heart with emphasis being given the mitral and aortic valves; on page 47, Willis Hurst makes some "Comments on Auscultation of the Heart," with particular reference to the intensity of the first heart sound. The *Journal* presents this article in special recognition of "Heart Month" and also wishes you a happy Valentine's Day.

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The Date: April 28-May 1, 1957.

The Place: Hotel De Soto, Savannah, Georgia.

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GUEST SPEAKERS FROM OVER THE NATION

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Stewart H. Clifford, M.D.
Brookline, Mass.

Orthopedics
Mary Sherman, M.D.
New Orleans, La.

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A. C. Furstenberg, M.D.
Ann Arbor, Mich.

Neurosurgery
Irving S. Cooper, M.D.
New York City

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Frank R. Lock, M.D.
Winston-Salem, N. C.

Medicine
James V. Warren, M.D.
Durham, N. C.

Thoracic Surgery
Donald Effler, M.D.
Cleveland, Ohio

Anesthesiology
David A. Davis, M.D.
Chapel Hill, N. C.

Industrial Surgery
Southgate Leigh, Jr., M.D.
Norfolk, Va.

Radiology
John R. Hodgson, M.D.
Rochester, Minn.

Surgery
Robert H. Coffey, M.D.
Washington, D. C.

Anesthesiology
Paul W. Searles, M.D.
Chicago, Ill.

Public Health
Paul Lemkau, M.D.
New York City

Medicine
William B. Rawls, M.D.
New York City

Medicine
Clifford F. Gastineau, M.D.
Rochester, Minn.

Urology
Ormond S. Culp, M.D.
Rochester, Minn.

Industrial Surgery
Harvey Nelson, M.D.
Minneapolis, Minn.

Medicine
Chester Keefer, M.D.
Boston, Mass.

Non-scientific, medically related topics on the program include a discussion of "Social Security and the Physician" to be presented by Mr. C. Joseph Stetler, Director, AMA Law Department, Chicago, and Mr. James W. Murray, Old Age and Survivors' Insurance Bureau, Social Security Administration Regional Office, Atlanta. Also scheduled is a program on "Accidents In and Around the Home," presented as the first of a series of MAG programs destined to institute preventive measures against accidents at home, work, recreation and travel.

The Association's House of Delegates, composed of duly elected representatives of the component county medical societies, will conduct the business and set the policies of the MAG in their two afternoon sessions held at the time of the annual meeting. Also two general business sessions for all MAG members will be convened to elect officers and councilors and present awards.

Scientific exhibits will be displayed to graphically present the latest developments in the field of medicine. Approximately 50 commercial exhibits have been arranged to provide further information for physicians.

The 16 Georgia Specialty Societies, cooperating with the Association in arranging the 1957 Annual Session program, are to be commended on their efforts in selection of speakers and topics. The excellence of the 1957 Session program is largely due to the untiring efforts of the program chairman representing these specialty societies which are listed as follows:

GEORGIA SPECIALTY SOCIETIES COORDINATING 1957 MAG ANNUAL SESSION

Georgia Diabetes Association
Georgia State Obstetrical and Gynecological Society
Georgia Society of Anesthesiologists

Georgia Chapter, American College of Surgeons
Georgia Pediatric Society
Georgia Orthopedic Society

Georgia Urological Society
 Georgia Academy of General Practice
 Georgia Psychiatric Association
 Georgia Radiological Society
 Georgia Association of Pathologists

American College of Physicians
 Georgia Chapter, American College of Chest Physicians
 Georgia Trudeau Society
 Georgia Society of Ophthalmology and Otolaryngology
 Georgia Industrial Surgeons Association

Your attention is called to the list of commercial exhibitors who will display their products or services at the 1957 Annual Session. These firms deserve every physician's support, as their cooperation in turn supports this meeting. Please remember the firm's product or service so that your Association may continue to have the cooperation of these exhibitors and thereby retain the overall excellence of MAG Annual Sessions. Accordingly you are asked to visit every commercial exhibit booth support the following firms:

COMMERCIAL EXHIBITORS DISPLAYING AT THE 1957 ANNUAL SESSION

<i>Booth No.</i>	<i>Name</i>	<i>Booth No.</i>	<i>Name</i>
1	Pet Milk Company, 1401 Arcade Bldg., St. Louis, Missouri	29	Westwood Pharmaceuticals, 468 DeWitt Street, Buffalo 13, New York
2	Rhinopto Company, 3905 Cedar Springs, Dallas, Texas	30	J. B. Roerig & Co., 536 Lakeshore Drive, Chicago 11, Illinois
3	Ross Laboratories, 585 Cleveland Avenue, Columbus 16, Ohio	31	U. S. Vitamin Corp., 25 East 43rd Street, New York 17, N. Y.
4	Ortho Pharmaceutical Corp., Raritan, New Jersey	32	A. S. Aloe Company, 5050 Peachtree Road, Chamblee
5	E. R. Squibb & Sons, 745 Fifth Avenue, New York 22, N. Y.	33	A. H. Robins Company, Inc., 1407 Cummings Drive, Richmond 20, Va.
6	Doho Chemical Corp., 100 Varick Street, New York 13, N. Y.	34	Lloyd Brothers, Inc., 1016 Mound Street, Cincinnati 3, Ohio
7	Desitin Chemical Company, 812 Branch Ave., Providente 2, R. I.	35	Hart Drug Company, 25 Northeast 25th Street, Miami 30, Fla.
8	Schering Corp., 2 Broad Street, Bloomfield, New Jersey	36	Julius Schmid, Inc., 423 D. 55th Street, New York 19, New York
9	C. B. Fleet Company, Drawer 1100, Lynchburg, Virginia	37	Donley-Evans & Company, 6300 Ouida Avenue, St. Louis 15, Mo.
10	Warner-Chilcott Labs., 113 West 18th Street, New York, N. Y.	38	Medco Products Company, 3603 East Admiral Place, Tulsa 12, Okla.
11	Lederle Laboratories Division American Cyanamid Co., Pearl River, N. Y.	40	Kremers-Urban Company, 141 West Vine Street, Milwaukee 1, Wisconsin
12	Parke Davis & Company, Joseph Campeau at the River, Detroit 32, Mich.	41	Van Pelt & Brown, Inc., 1328 E. Main Street, Richmond 4, Va.
13	Ciba Pharmaceuticals, LaFayette Park, Summit, New Jersey	42-43	Wachtel's Physician Supply Co., 406-10 Bull Street, Savannah
14	Chas. C. Haskell & Co., Inc., 9 South Harvey St., Richmond, Va.	44	DeLeon Laboratories, 134 Houston Street, N.E., Atlanta 3
15	Merck, Sharp & Dohme Co., Inc., 640 Broad St., N., Philadelphia 1, Pa.	45	Coca-Cola Company, P. O. Drawer 1734, Atlanta 1
16	Bristol-Myers Products Division, 630 Fifth Avenue, New York 20, N.Y.	46	Eli Lilly & Company, P. O. Box 618, Indianapolis 6, Indiana
20	Hoffmann-LaRoche, Inc., Roche Park, Nutley 10, New Jersey	47	American Ferment Co., Inc., 1450 Broadway, New York 18, N. Y.
22	Abbott Laboratories, North Chicago, Illinois	48	Chas. Pfizer & Co., 630 Flushing Avenue, Brooklyn 6, New York
23	Winthrop Labs., Inc., 1450 Broadway, New York 19, N.Y.	49	J. B. Lippincott Co., East Washington Square, Philadelphia 5, Pa.
25	The Wm. S. Merrell Co., Dept. Professional Services, Cincinnati 15	50	Holland Rantos Company, Inc., 146 Hudson Street, New York 13, N. Y.
26	Baxter Laboratories, Inc., 6301 Lincoln Avenue, Morton Grove, Ill.	51	G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois
27	Wm. P. Poythress & Co., Inc., Richmond, Virginia		
28	Eaton Laboratories, Inc., Norwich, New York		

Spontaneous Rupture of the Common Bile Duct During Pregnancy

JASPER T. HOGAN, JR., M.D., Macon, Georgia

THE RARITY OF THE PHENOMENON of choledochal rupture occurring in any state was elucidated by Chodoff,¹ who, in 1954, reported the fourteenth case of spontaneous rupture of the common bile duct without history of antecedent surgery or trauma. A report of spontaneous rupture of the common bile duct during pregnancy has to my knowledge not heretofore been published.

First to arouse the curiosity and interest in this subject of biliary duct rupture was McWilliams.² In the year 1912 there was introduced to the profession his preclusion of 90 cases of perforations in the extra hepatic biliary system due to all causes; of these 90, 91 per cent occurred in the gallbladder, 4.4 per cent in the common duct, 3.3 per cent in the cystic duct and 1.1 per cent in the hepatic ducts. In 1935 Wolfson³ reported three cases of spontaneous rupture of the common bile duct following choledochostomy. In 1941 Taube⁴ reported one case of spontaneous rupture associated with chronic cholecystitis and cholelithiasis, and in the same year Newell⁵ also reported one case without previous surgery or trauma. Dreiling⁶ in 1947 reported one case following choledocholithotomy, and Gans⁷ in the same year reported a case of spontaneous rupture associated with a stone in the process of eroding through the common duct wall. A case due to gangrene of the common duct and the adjacent gallbladder filled with stones was published by Hart⁸ in 1951. The next month Garipey⁹ reported two cases of his own and three others not mentioned above. The aforesaid presents lucid evidence of the rarity of spontaneous rupture of the common bile duct. The etiologies have been well outlined by Gans⁷ who lists as the major non-traumatic causative agents common duct stones, choledochitis, and increased intraductal pressure.

Case Report

N. C., a 27-year-old, white, married female, para 3 gravida 4 aborta 0, was admitted to the hospital Oc-

tober 15, 1953, at 9:10 P.M. with a history of epigastric pain since the evening before. The patient had been seen in the office on the morning of the day of admission with the above complaint. The pain was stationary in location and constant in severity without radiation, but breathing was aggravating the pain. There was a history of a "chest cold" for about 72 hours. Positive findings on examination in the office revealed a low grade fever, bilateral moist rales, epigastric tenderness, and an intra-uterine pregnancy of about seven months duration. Impression in the office was acute bronchitis, nasopharyngitis with possible basal pleurisy, and a normal intra-uterine pregnancy. The patient was given intramuscular penicillin and streptomycin, an expectorant, and an antihistamine; she was told to go home and contact her physician if she did not improve. Late that evening she was admitted to the hospital with a history of a sudden right lower quadrant pain that began that afternoon and had gradually become worse.

Examination on admission revealed little in the way of additional findings except what appeared to be voluntary muscle spasm and uterine tonic. The patient grew worse during the night and developed definite signs of peritoneal irritation, a white blood cell count that exceeded 25,000, and 80 per cent polymorphonuclear leukocytes. Consultation was obtained with her obstetrician who agreed that some type of acute intra-abdominal surgical condition existed that was concomitant with, but not directly associated with, her pregnancy. The presumptive emergent clinical diagnosis was acute cholecystitis or appendicitis.

An exploratory laparotomy through an upper right quadrant paramedian incision was made. On opening the abdomen, it was noted to be filled with bile. The biliary system was explored with difficulty because of the gravid uterus. However, bile was seen oozing from an opening about one mm. in size on

the ventral surface of the common duct about one cm. below the cystic duct junction. Palpation of the common duct through the foramen of Winslow revealed no stones and no detectible induration of the common duct, although some induration of the adjacent duodenum was felt. A Bakes common duct dilator size five mm. was introduced into the duodenum without difficulty. The gallbladder appeared normal. Because of the condition of the patient, the difficult exposure problem, and the tetanic uterus, a choledochogram during surgery was considered imprudent; consequently, a "T" tube was inserted into the common duct at the perforation site, and the various peritoneal gutters were drained. The immediate postoperative condition of the patient was satisfactory, but the status of the fetus was imperiled by a tetanic uterus with a persistent fetal pulse that exceeded 140 beats per minute.

In spite of nasal oxygen, intravenous fluids, antibiotics, and intensive general supportive therapy, a stillborn infant was delivered on the fourth postoperative day. By this time a stormy course of bile peritonitis was well under way. Fever rose above 103 degrees F., the sensorium became depressed, drainage from the surgical wound was profuse, and an electrolyte disturbance henceforth plagued us for weeks. On the seventeenth postoperative day it was felt that the patient's condition would safely allow a choledochogram through the "T" tube. This revealed "migration stones in the common and hepatic ducts with one stone impacted at the ampulla". On several occasions following the above discovery, nitroglycerin 1/100 grain was given sublingually while simultaneously "T" tube medications of 10 cc. of one per cent procaine hydrochloride were given; this was followed by one cc. of ethyl ether succeeded by a generous irrigation with normal saline solution. In the meantime the patient complicated her already serious state by developing a right pyelonephritis manifested by a severe pyuria, higher fever, and tenderness over the right kidney region. An intravenous pyelogram was negative. This new infection was rapidly quelled with sulfisoxazole. Not once during her first 79 days did the white blood count drop below 20,000.

Daily intubations of a Levin tube into the stomach were done to permit feedings of "T" tube bile to promote better electrolyte balance. By the eighty-eighth postoperative day a choledochogram was reported as "showing no stones but persistent slight dilation of the common bile duct." A barium swallow showed "no gastric or duodenal pathology." Forty-eight hours later the "T" tube was removed. The resultant fistula began to slowly close. By the hundredth postoperative day an emaciated but live and happy patient left for home. Her outpatient follow-up was without event.

Summary

The above is a case of nontraumatic spontaneous rupture of the common bile duct occurring in a gravid female who had had neither previous biliary surgery, trauma, or history revealing prior biliary system disease. Her postoperative course of a stillborn infant, severe bile peritonitis, pyelonephritis, and a marked electrolyte disturbance became a harrowing surgeon's-nightmare. She was discharged from the hospital, an almost living corpse, and yet today can tell you she has since delivered a full term, normal infant and can digest peanuts and rutabagas with an air of defiance.

781 Spring Street

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Do You Know?

DURING THE LAST war, one out of every eight men examined at induction centers was rejected for neuro-psychiatric disorders, and the total loss in manpower from mental illness was enough to man 177 army infantry divisions.

At least 65% of the mentally ill can get well with proper treatment, but so few are getting it that today

there are more than 750,000 patients in the mental hospitals—more than there are in all other hospitals combined.

It is estimated that \$3,500,000,000 is lost in earnings and \$418,000,000 is lost in federal income tax each year because of mental illness. Now is the time to join the fight on mental illness.

Some Comments on Auscultation of the Heart

I. The Intensity of the First Heart Sound at the Apex

J. WILLIS HURST, M.D., Emory University, Georgia

THE SECRET OF CARDIAC auscultation is to *listen to one thing at a time and to listen specifically for something*. In an effort to expose this secret more completely the following illustration is presented.

Imagine you are now listening to the cardiac apex. During the first few moments of auscultation one is conscious of the first and second heart sounds, but if the examination ceases at this point the true characteristics of each sound can seldom be described. One must listen specifically to the first heart sound in order to obtain the maximum information that auscultation in this area can yield. In this discussion the information will be described that can be obtained by listening specifically to the intensity of the first heart sound at the apex. A similar approach should be used in auscultation in general, that is, to concentrate on one thing at a time and to listen specifically for the various sounds and murmurs.

The Auscultatory "Areas" for Heart Sounds. (Figure 1) The aortic "area" is located in the second

From the Department of Medicine, Emory University School of Medicine, Atlanta, Ga.
Presented at the Annual Session of the Medical Association of Georgia, Atlanta, May 15, 1956.

right intercostal space adjacent to the sternum, the pulmonary "area" is located in the second and third left intercostal spaces adjacent to the sternum, the tricuspid "area" is located at the lower end of the sternum and the mitral "area" is located at the apex. The anatomical locations of the heart valves are different from the auscultatory "areas." In fact, all of the heart valves are rather close to each other. The auscultatory areas for heart sounds should not be confused with the auscultatory areas for heart murmurs since murmurs radiate in various directions. For example, the aortic second sound is studied in the second right interspace adjacent to the sternum while the murmur of aortic regurgitation is sought for in the aortic area, along the left sternal border and at the apex.

It is good to have the habit of listening for the various sounds and murmurs in an orderly manner. It seems reasonable to listen to the aortic area, then to the pulmonary area, then along the left sternal border, then at the lower end of the sternum, and finally to the apex. The second heart sound is usually louder than the first heart sound in the aortic area in the adult except when there is aortic stenosis

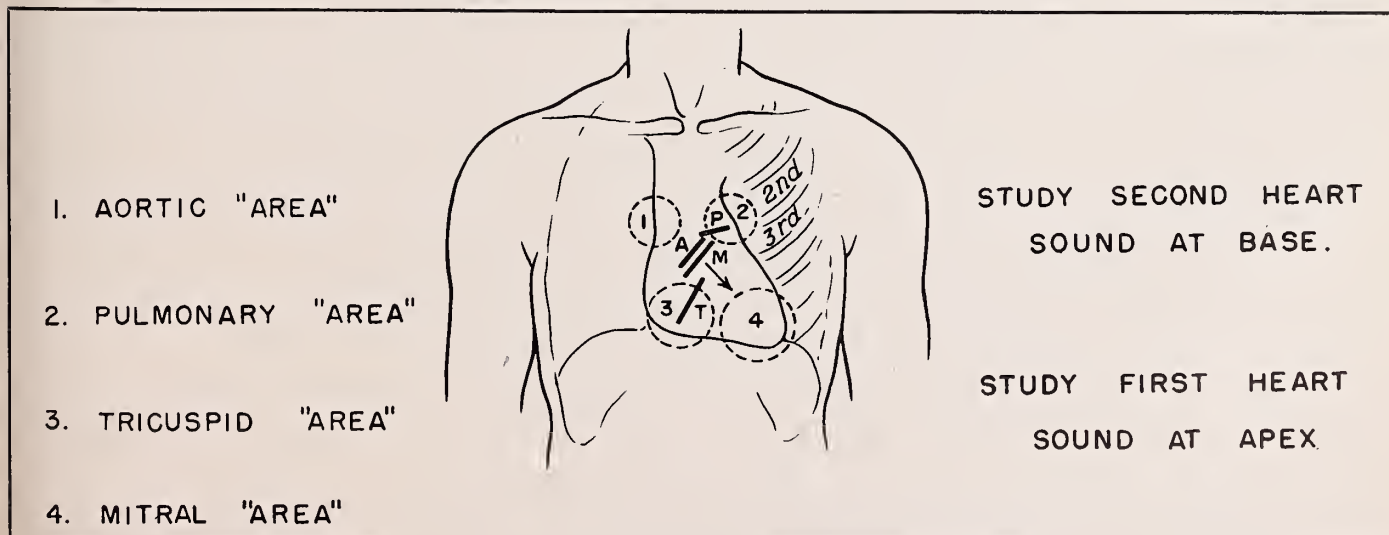


Figure 1
Auscultatory "Areas" for Heart Sounds

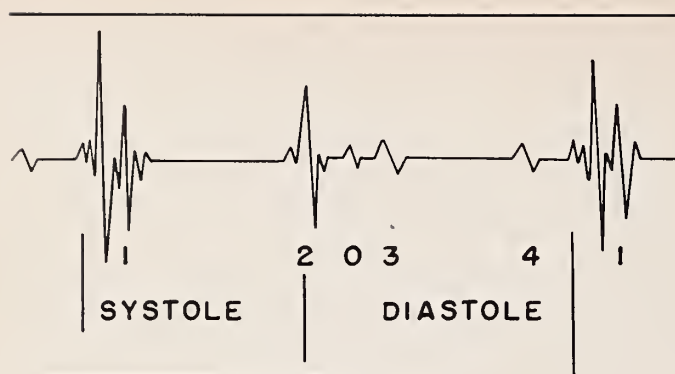


Figure 2

or when the pulmonary second sound is unusually loud for some reason. Accordingly, the loud second sound in the aortic area can serve as an auscultatory "base line" and should be identified before one focuses upon any other sounds or murmurs. This simple observation may help the beginner to identify systole and diastole when they are of equal duration. The first heart sound is usually louder than the second heart sound at the apex in normal subjects. *One must learn to study the second heart sound in the aortic and pulmonary areas, sometimes called the base of the heart, and to study the first heart sound at the cardiac apex.*

Now, imagine that you are listening to the first and second heart sounds at the cardiac apex. After these sounds have been identified, listen specifically for the opening snap of the mitral valve, for a diastolic gallop sound (same timing as the third heart sound), and for a fourth or auricular sound (Figure 2). Now, before listening specifically for murmurs, concentrate on the first heart sound. Concentrate on that particular sound so intently that none of the other sounds or murmurs are heard. This discussion will deal with the loudness of the first heart sound at the apex.

First Heart Sound

Components of the First Heart Sound (Figure 3).

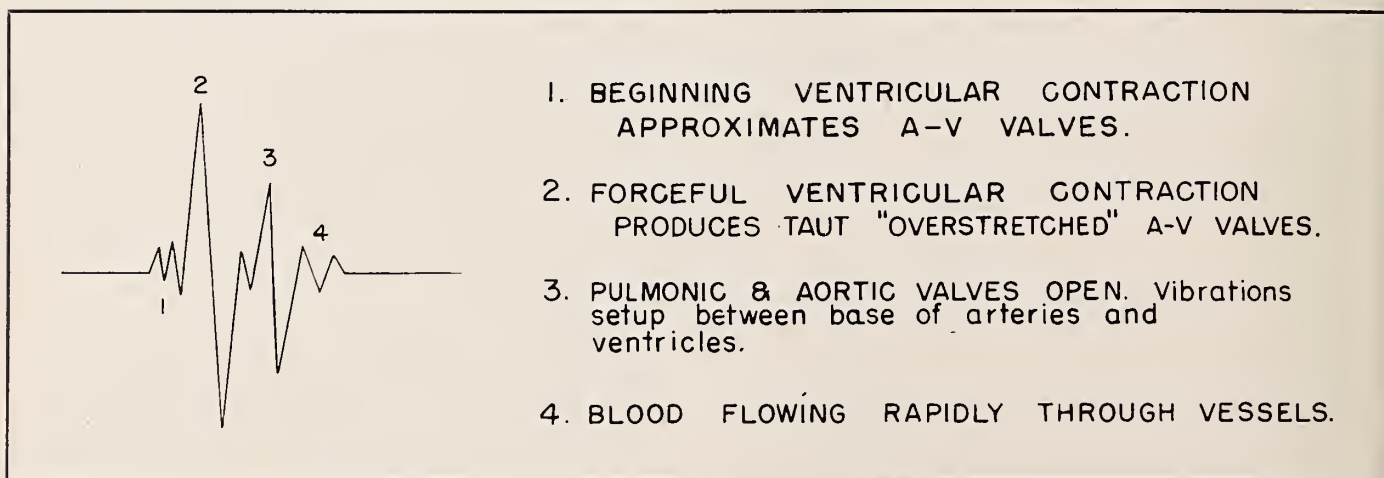


Figure 3

Components of the First Heart Sound
(Audible Portion Due Mainly to Mitral Valve Closure)

The first heart sound is made up of four components.¹ The first component is produced when the ventricles begin to contract and force the mitral and tricuspid valves to close. The second component is produced when the ventricles contract vigorously, forcing the blood against closed A-V valves. This produces taut over-stretched valves which result in vibrations between the valves and the contracting ventricles. The third component occurs when the aortic and pulmonic valves are forced open by the rising pressure within the ventricles, and the surging blood is abruptly halted by the more "stationary" blood columns in the aorta and pulmonary artery. Vibrations are thereby set up between the base of the arteries and the ventricles. The fourth component is produced by vibrations which result from the blood flowing rapidly in the first portion of the aorta and pulmonary artery.

The first and fourth components of the first heart sound are not usually audible. The second component of the first heart sound probably contributes more to the intensity of the sound than does the third component. As stated, the second component of the first heart sound is associated with the sudden tensing of the closed mitral and tricuspid valves. This component of the first sound is frequently split due to asynchronous closure of the mitral and tricuspid valves. Under such circumstances the tricuspid valve usually closes earlier and produces the first part of the split. The tensing of the mitral valve probably contributes more to the intensity of the first sound than does the tensing of the tricuspid valve since the intraventricular systolic pressure attains higher levels in the left ventricle than in the right ventricle.

As you are listening to the first heart sound at the cardiac apex it seems logical from the foregoing to think in terms of A-V valve closure. In addition, for simplicity, it seems reasonable to think in terms of mitral valve closure.

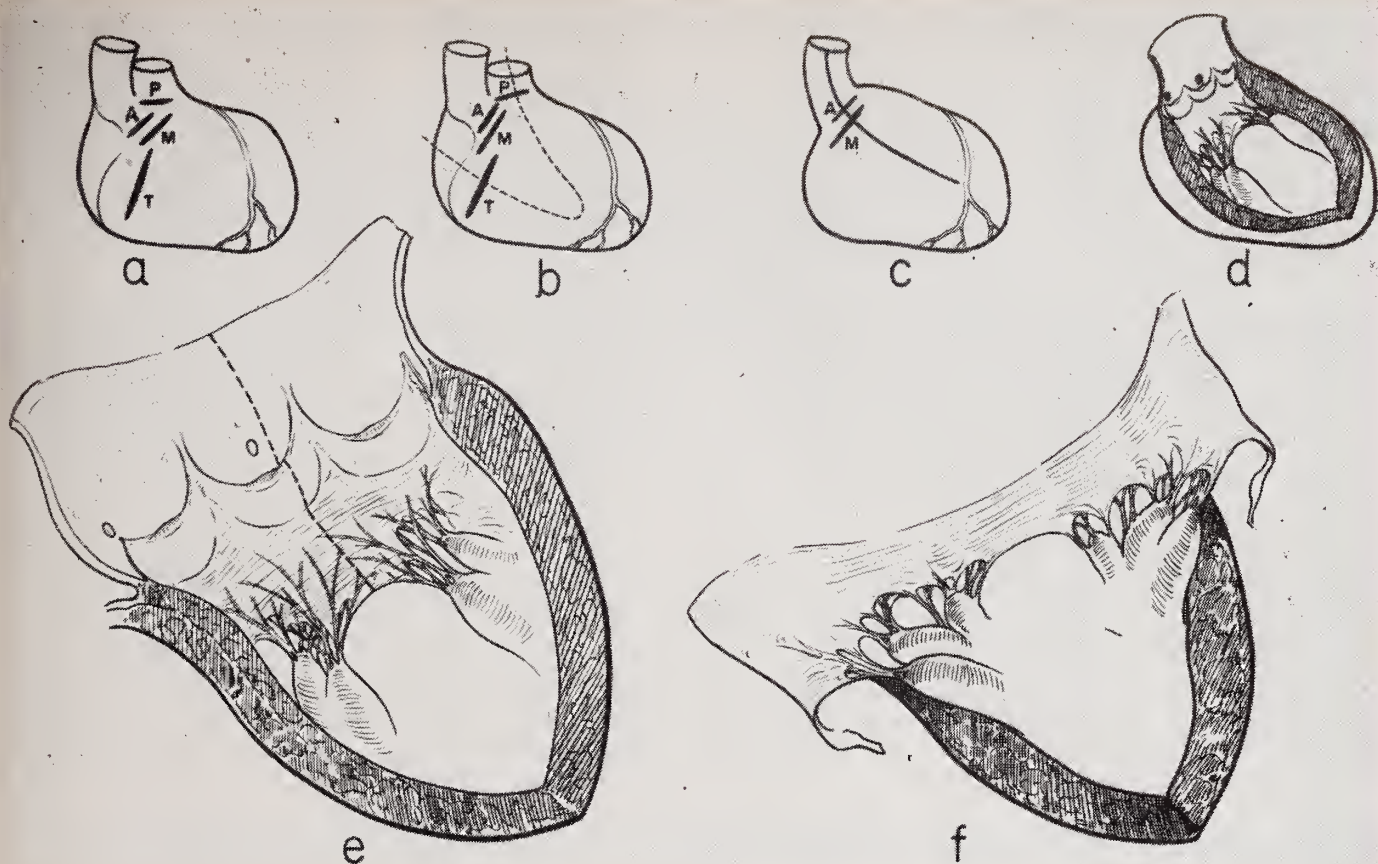


Figure 4

The Mitral Valve

The Anatomy of the Mitral Valve. Since it is the closure of the mitral and tricuspid valves that produces the first heart sound, it is useful to know certain anatomical characteristics of these valves. In the usual clinical problem it is satisfactory to think only in terms of mitral valve closure. Accordingly this valve—the mitral valve—is described in detail. Figure 4 illustrates the location of the various heart valves and an unusual view of the mitral valve.

An attempt was made to retain the cardiac orientation outside the body that was present prior to the removal of the heart. Figure 4a indicates the position of the heart valves as they were located by palpation. The right atrium, tricuspid valve, right ventricle, and pulmonary valves were incised along the indicated line, and the valves on the right side of the heart were visualized as depicted in Figure 4b. The right atrium and right ventricle were then removed, leaving the interventricular septum, left ventricle, and aorta, Figure 4c. The aorta and interventricular septum were incised along their most anterior surface and the aortic and mitral valves were visualized, Figure 4d. Figure 4e shows an enlarged drawing of the relationship of the anteromedial (aortic) leaflet of the mitral valve and the aortic valve. This leaflet lies below the aortic valve and channels the blood toward the aortic outlet during ventricular ejection. The aortic leaflet of the mitral valve is quite large, where-

as the posterolateral leaflet of the mitral valve is short. (Figure 4f. Incision made through the aortic valve and aortic leaflet of the mitral valve.)

All the cardiac valve rings are close together and actually have a common fibrous framework. The mitral valve ring is much larger than the opening made by the edges of the mitral valve leaflets. These remarkable leaflets project downward into the ventricular chamber, and their edges are forced to remain there at all times by the chordae tendineae and papillary muscles. Note in Figure 4e that there are two sets of papillary muscles and that these may divide again. The attachments of the chordae tendineae to the valve leaflets are very interesting. The chordae tendineae that attach to the large aortic leaflet of the mitral valve frequently divide into two strands. One strand inserts on the free edge of the valve leaflet, and the other strand inserts into the body of the leaflet. The chordae tendineae that attach to the short posterolateral leaflet usually insert at the edge of the valve. The unique part of this arrangement is that the chordae tendineae from one papillary muscle may insert on both leaflets of the mitral valve. Accordingly, when the papillary muscles contract, the mitral valve leaflets are forced toward each other and at the same time the valve edges are forced to remain deep within the ventricular chamber.

The Movement of the Mitral Valve. Many theories have been developed to describe the movements of

the mitral valve but none have been totally satisfactory.¹ The mitral valve leaflets never separate widely and they never herniate into the left atrial cavity. During ventricular diastole and prior to auricular systole the mitral valve leaflets are slightly separated and can be assumed to be in a position of "rest." During atrial systole the mitral valve leaflets are forced open slightly. A "jet" effect is produced at the end of atrial systole due to the negative pressure that results when the flow of the blood through the mitral orifice is suddenly halted. This negative pressure forces the mitral valve leaflets toward each other. The leaflets are probably farther apart at this point, however, than they were during the "resting" state. The movements just described force the central portion of the valve leaflets inward more than the valve edges. Following this, the early phase of ventricular contraction forces the valve leaflets together. This movement prevents mitral regurgitation from occurring. This is followed by vigorous ventricular contraction which causes the mitral valve to "buckle." It is the "tensing" and "buckling" of the mitral valve that contributes most of the sound to the second component of the first heart sound.

The Mitral Valve and a French Door. Mitral and tricuspid valve closure are responsible for 90 per cent of the intensity of the first heart sound. Mitral valve closure contributes more to the first sound than does the closure of the tricuspid valve. Because of this and for simplicity, only the mitral valve will be illustrated. The mitral valve is somewhat similar to a French door (Figure 5). The two doors represent the valve leaflets, and the door frame represents the mitral valve annulus. There are, however, more differences between the mitral valve and a French door than there are similarities. The doors as drawn are of equal size whereas the aortic leaflet of the mitral valve is long and hangs like a curtain below the aortic valve ring while the posterolateral leaflet of the mitral valve is much shorter. When French doors are closed only their edges become approximated, whereas the closure of the mitral valve

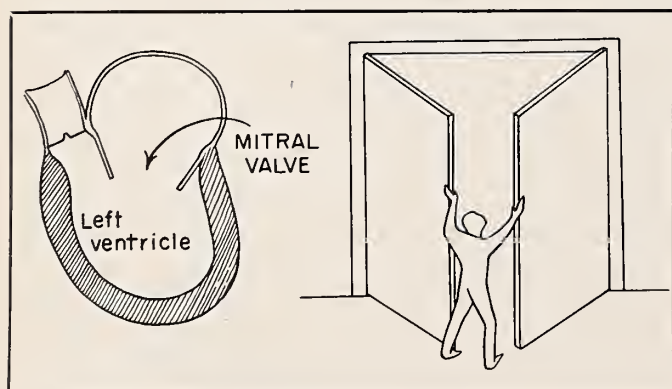


Figure 5

The Mitral Valve and a French Door

is very different since the "bodies" of the mitral valve leaflets begin to close before the edges of the leaflets close. When a French door is closed it is "flush" with the door frame, but the closed mitral valve is not "flush" with the mitral valve annulus. In fact, the mitral valve leaflets are retained deep in the ventricular cavity at all times by the chordae tendineae. A French door opens through a wide arc, whereas the mitral valve leaflets move relatively little by comparison. When a French door is opened wide the entire door area becomes open. The mitral valve is different because the lower end of the "funnel-like" mitral valve is much smaller than the base of the mitral valve.

Despite the many differences between the mitral valve and a French door such an analogy will be used in order to describe and emphasize certain points in a simple manner. If the mitral and tricuspid valves are both illustrated as French doors, then asynchronous closure of the doors produces splitting of the first heart sound. When studying the loudness of the first sound one must listen specifically to the loudness of the sound. To hear splitting of a sound one must listen specifically for splitting. This discussion deals only with the intensity of the first heart sound.

The left atrium, mitral valve, left ventricle, aorta, and a French door are shown in Figure 5. The little man illustrates ventricular force. One can reason that the loudness of valve closure depends upon the following three things (Figure 6):

1. The position of the A-V valves at the onset of ventricular systole. (Related to the P-R interval.)
2. The "force" of ventricular contraction.
3. The structure of the valve itself.

The counterpart of these three factors can be seen in the drawing of the French door. That is, the loudness of a door closure depends on how wide the door is open when closure commences, how forcefully the door is closed, and what the door is made of. These three factors will now be discussed in detail.

The Position of the A-V Valves at the Beginning of Ventricular Systole (Figure 7). The position of

THE INTENSITY OF THE FIRST HEART SOUND DEPENDS UPON:

1. THE POSITION OF THE HEART VALVES AT THE ONSET OF VENTRICULAR SYSTOLE (Related to P-R interval)
2. THE "FORCE" OF VENTRICULAR CONTRACTION
3. THE "STRUCTURE" OF THE VALVE ITSELF

Figure 6

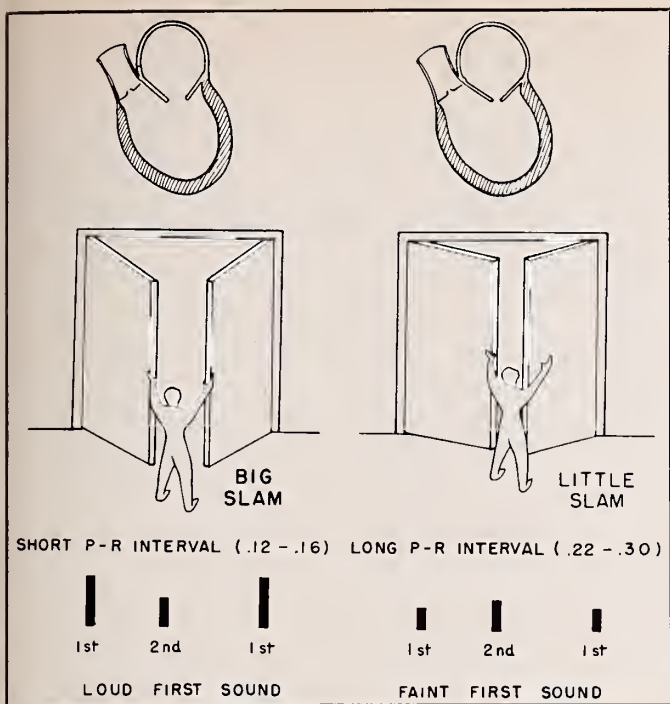


Figure 7

The Position of the Mitral Valve at the Onset of Ventricular Systole (Position Related to P-R Interval).

the A-V valves at the beginning of ventricular contraction is one of the variables that determines the intensity of the first heart sound.² The position of the A-V valve leaflets is related to the P-R interval. When the P-R interval is normal or short (.12-.16 seconds) the valve leaflets are wide apart at the beginning of ventricular systole and a loud first sound will result. This compares to forcibly closing a door from a wide-open position. When the P-R interval is long (.22-.30 seconds) then the valve leaflets have time to float toward each other during the pause, and the valve leaflets are less far apart at the beginning of ventricular systole. This results in a faint first sound and compares to closing a door from the slightly open position. Evidence has been accrued from studying cases of complete heart block that indicates that when the P-R interval becomes *exceedingly* long the first sound again becomes loud.³

After closing many doors from the wide open and slightly open positions I seriously doubt if the intensity of the first heart sound depends on the exact position of the A-V valves at the beginning of ventricular systole. I suspect the real reason for a loud first sound being associated with a short P-R interval is much more subtle. I wonder if it is not a matter of "uninterrupted momentum" in the case of the short P-R interval and "interrupted momentum" in the case of a long P-R interval. When the P-R interval is short, ventricular systole would force the valves together in the wake of the "jet effect" which is already closing the valves and thereby make use of all the forces of momentum. This would cause a loud first sound. When the P-R interval is long the

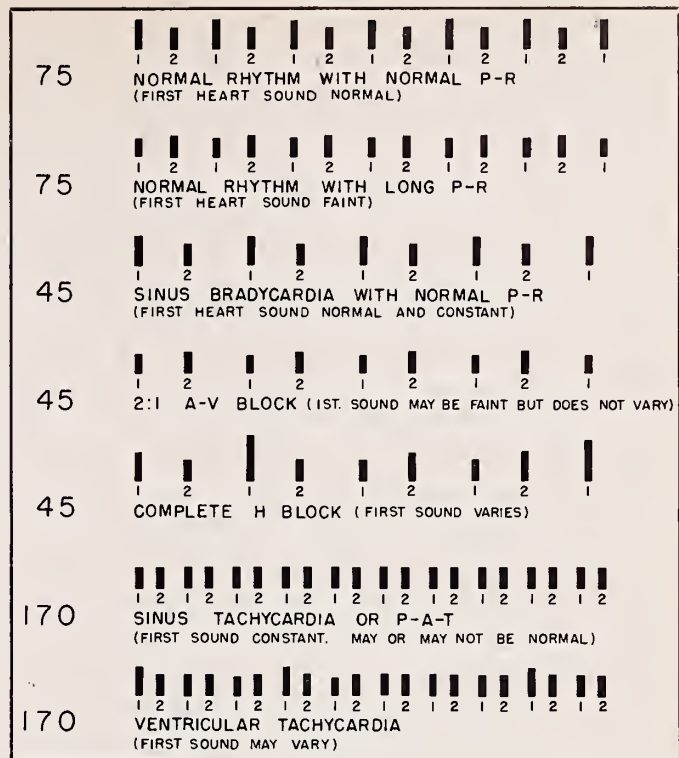


Figure 8

valve leaflets have time to assume a position of rest after the "jet effect". Under such circumstances, ventricular systole must overcome the inertia of a motionless valve. This would cause a faint first sound.

Some of numerous practical applications of this information are as follows (Figure 8). When following a case of rheumatic fever, the time the first heart sound is noted to be decreased is the time that partial heart block is more likely to be documented by electrocardiography. When following a case of myocardial infarction, a decreased intensity of the first heart sound should make one think of partial heart block or weak ventricular contraction. Suppose a regular heart rate of 45 is detected. Such a slow rate could be sinus bradycardia, 2:1 heart block, or complete heart block. The cardiac mechanism can usually be suspected at the bedside by a careful study of the intensity of the first heart sound at the apex. When there is sinus bradycardia and a normal P-R interval, the intensity of the first heart sound will be normally loud and does not vary from cycle to cycle. When there is 2:1 block the intensity of the first heart sound does not vary from cycle to cycle but may be decreased if the conducted beat is preceded by a long P-R interval. When there is complete heart block, the intensity of the first heart sound varies considerably from cycle to cycle because the relationship of atrial contraction and ventricular contraction also varies from cycle to cycle. When the P wave occurs shortly before the QRS, the first sound is loud; when the P wave precedes the QRS by as much as .22 to .30 second, then the first sound is decreased in intensity; and when the P wave occurs

a longer period of time before the QRS, then the first sound may become loud again. The changing intensity of the first heart sound at the apex in cases of complete heart block is a dependable sign—if it is looked for.⁴

Suppose a regular heart rate of 170 is encountered. There are many bedside observations, including response to carotid sinus pressure, that must be made. In this discussion I will describe only one of the observations that should be made; namely, a study of the intensity of the first heart sound at the apex. When there is paroxysmal auricular tachycardia or sinus tachycardia, the first sound does not vary from cycle to cycle because there is a constant relationship of P to QRS. The first sound is frequently normal but may be slightly increased when the heart rate is only moderately rapid or may be decreased with exceedingly rapid rates. The altered first sound, if present in such cases, is not determined by the P-R interval but is related to the rate itself and force of ventricular contraction. When there is ventricular tachycardia the first heart sound may vary in intensity from cycle to cycle because the relationship of P to QRS varies from cycle to cycle. This auscultatory finding is not always present in cases of ventricular tachycardia or is present to such a slight degree that one is uncertain of the observation. Accordingly, it is a helpful sign only when definitely present.

The "Force" of Ventricular Contraction (Figure 9). When ventricular contraction is powerful and abrupt, the closure of the A-V valves will be associated with a loud first sound. This compares to closing a door with great force. When ventricular contraction is weak, the closure of the A-V valves may be associated with a faint first sound. This compares to closing a door with little force. Powerful ventricular contraction and a loud first sound may occur with anxiety, thyrotoxicosis, exercise, tachycardia, after the administration of drugs such as adrenalin, etc.

In addition to the conditions just mentioned that may cause a decrease or increase in the first heart sound, two other conditions deserve attention. In addition to palpating the peripheral arteries and studying the blood pressure for pulsus alternans, attention should be paid to "auscultatory alternans". Occasionally the first and second heart sounds may alternate in intensity from beat to beat when the heart rate is normal. Both sounds actually alternate in intensity, but attention to the first sound specifically is the easiest clue to identify. At times murmurs may alternate from loud to faint from beat to beat when there is alternans implying a strong and weak contraction. In addition, as a search is made for alternans, "visual alternans" must not be overlooked

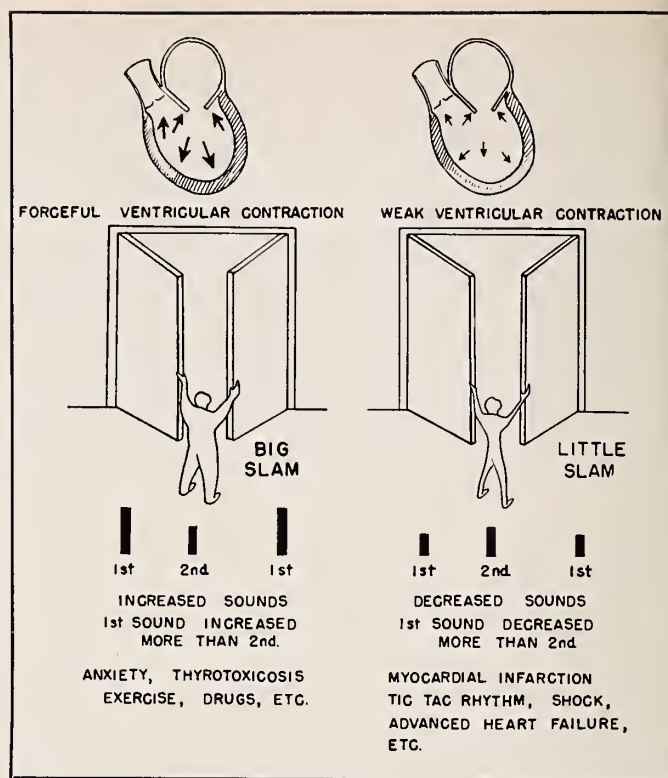


Figure 9
The "Force" of Ventricular Contraction

during fluoroscopic examination. That is, alternating weak and strong aortic or ventricular contraction may be detected during fluoroscopy. Pulsus bigeminy is the most common cause of an alternating strong and weak contraction and must not be confused with pulsus alternans.

The Structure of the Valve Itself (Figure 10). The noise a door makes when it is closed depends in part on the structure of the door. For example, a thin, delicate door would make less noise when closed than would a thicker and heavier door. The noise that mitral valve closure produces likewise depends upon the structure of the valve. The scarring secondary to rheumatic valvulitis leads to a thick and deformed valve. Mitral stenosis results when the valvulitis leads to fusion along the valve edges, and in such cases the valve opening may become very small and may be located eccentrically. Such a stenotic valve does not function normally. The valve may not open and may not close completely, and the opening itself moves very little. Under such circumstances ventricular systole causes rather abrupt bucklings of the "fused" mitral leaflets toward the left atrial cavity. This movement takes place to some degree in normal valves but is probably exaggerated in cases of mitral stenosis. This abrupt movement of fibrotic valves is responsible for the delayed, short, highpitched, and exceedingly loud first heart sound that is usually heard in cases of mitral stenosis. The opening snap of the mitral valve is often heard just after the second heart sound when listening to the apex in cases of mitral stenosis. The

same conditions that cause a loud "closing snap" or first sound are responsible for the "opening snap" in such cases. It is not difficult to imagine that the fibrotic mitral valve buckles again, this time toward the ventricular cavity, to cause the "opening snap". Since the valve does not really "open" in such cases, the term "opening snap" is misleading. The phenomenon just described can be likened to the noises made by a child's toy "cricket". A sharp, loud noise is made when the stiff, but still flexible, metal is pressed firmly with the thumb. This sound could represent the loud first sound of mitral stenosis. When the thumb is released another sound is made which could represent the "opening snap" of the mitral valve. A loud first heart sound and an "opening snap" of the mitral valve usually imply a certain degree of flexibility of the valve since valvular bulging or the "cricket phenomenon" is possible only if the doors are somewhat thicker than average but are still flexible. Note also in Figure 10 that the mitral valve buckles toward the left atrial cavity during ventricular systole. The reverse of this movement causes the "opening snap" of the mitral valve to occur just after the second heart sound.

On rare occasion the mitral valve is so rigid due to calcification that it is not flexible. Under these rare circumstances the valve does not buckle toward the left atrial cavity, and the first heart sound may

not be loud. The "cricket phenomenon" cannot exist unless the valve is flexible. This is illustrated in Figure 10 as the "solid" door. If valve buckling does not occur with the strong force of ventricular contraction it is unlikely that it can occur after systole. Accordingly, it can be reasoned that when there is advanced stenosis with rigid valves that cannot move the first heart sound may not be loud, and in such cases an "opening snap" is not likely to be heard.

It is essential to constantly remember that a loud first heart sound at the apex may be the first clue to mitral stenosis. When such a sound is heard, it is imperative to listen carefully for the characteristic diastolic rumble of mitral stenosis using the bell of the stethoscope, applying just enough pressure to make an air seal, and listening at and around the apex impulse after exercise with the patient in the left lateral recumbent position. The "opening snap" of the mitral valve is also "listened for" in such cases. Certainly most cases of significant mitral stenosis have a loud first heart sound, but occasionally, as previously discussed, patients with advanced mitral stenosis may not have an exceedingly loud first sound since some degree of valve flexibility is needed to make a loud sound.

All that rumbles is not mitral stenosis. For example, low-pitched diastolic rumbles can be heard in cases of interatrial septal defect, interventricular

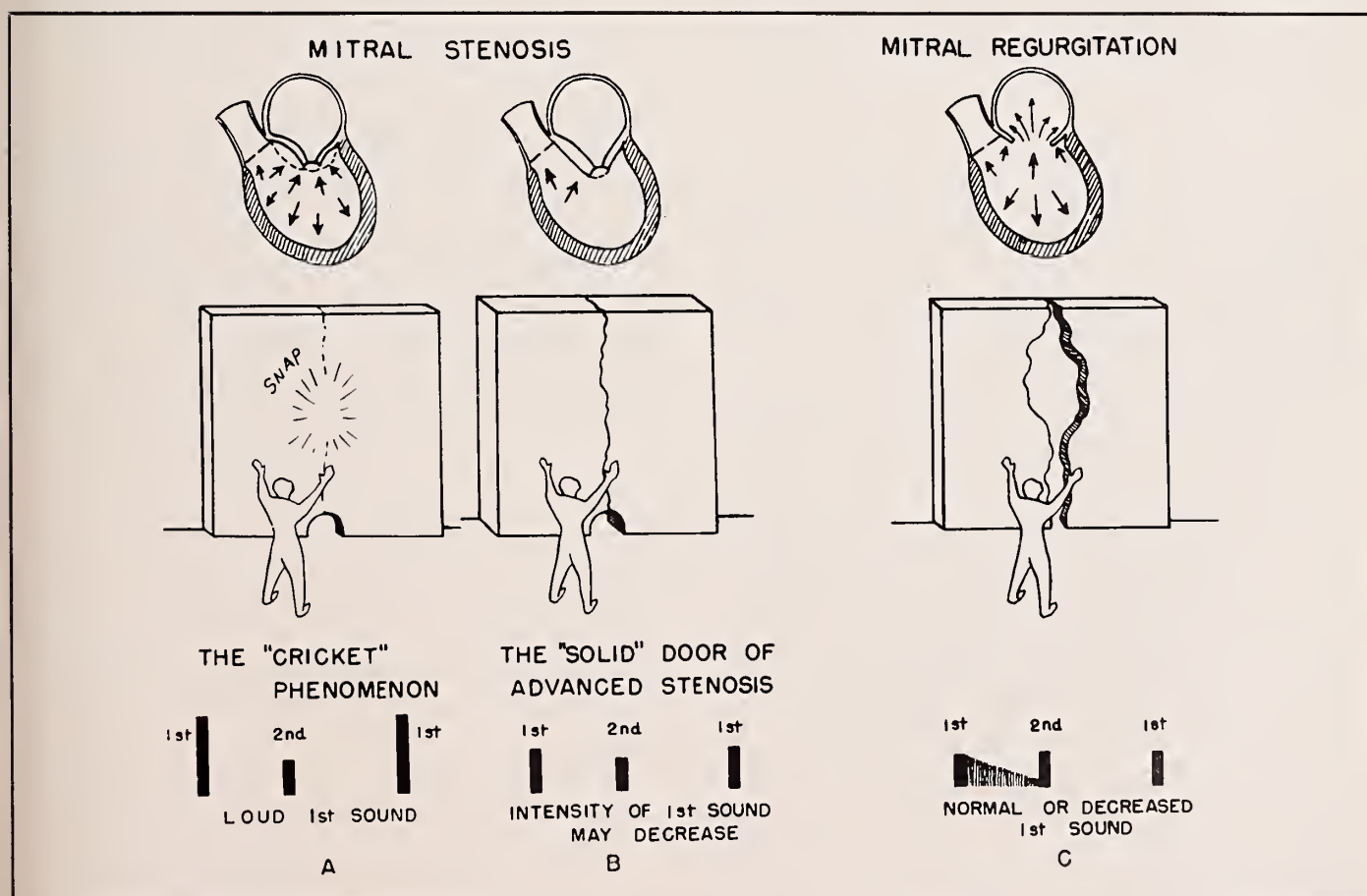


Figure 10
The "Structure" of the Mitral Valve and the Intensity of the First Heart Sound

septal defect, patent ductus arteriosus, and severe anemia. These murmurs are called "flow" murmurs and will be discussed in detail in a later article. Another cause of a diastolic rumble at the apex is the Austin Flint murmur. The Austin Flint murmur is defined as a diastolic rumble at the apex in cases of aortic regurgitation. The mechanism for such murmur is not clear, but I am convinced, after dissecting several hearts, that aortic regurgitation could easily force the aortic leaflet of the mitral valve toward a closed position. In such cases the mitral valve itself is normal, and a loud first heart sound and opening snap are not routinely heard. In other words, a loud first heart sound and the opening snap of the mitral valve are not heard with "flow murmurs", with the Austin Flint murmur, and with "relative stenosis" due to cardiac dilatation. Stated another way, a diastolic rumble with a loud first sound and an opening snap is excellent evidence of organic mitral stenosis.

Auricular fibrillation with a normal mitral valve is usually accompanied by a first and second heart sound that varies in intensity from cycle to cycle. When auricular fibrillation is associated with mitral stenosis, the first heart sound at the apex is frequently loud and varies less than when there is auricular fibrillation alone.

The first heart sound may be decreased in intensity when there is mitral regurgitation. There are two reasons for this. Coaptation of the mitral valve edges may not be possible in such cases and the first sound may be replaced and "masked" by the systolic murmur (Figure 10).

Summary

1. The secret of cardiac auscultation is to listen to one thing at a time and to listen specifically for something.

2. In this discussion the reader was asked to imagine that he was listening specifically to the intensity of the first heart sound at the apex.

3. The first heart sound is produced by closure of the mitral and tricuspid valves. Mitral valve closure

probably contributes more to the loudness of the first sound than does tricuspid valve closure.

4. The anatomy and movement of the mitral valve is discussed and is compared and contrasted with a French door.

5. The intensity of the first heart sound at the apex depends upon:

- (a) The position of the A-V valves at the onset of ventricular systole. (Related to P-R interval.)

- (b) The "force" of ventricular contraction.

- (c) The structure of the valve itself.

6. This information allows one to make many practical observations at the bedside. For example, an exceedingly loud first heart sound should force one to consider a short P-R interval, a hyperactive heart, or mitral stenosis.

When the first heart sound varies from cycle to cycle and the heart rhythm is regular at a rate of 45, then one should suspect complete heart block.

When the first heart sound varies from cycle to cycle and the heart rate is regular at a rate of 170, then one should suspect ventricular tachycardia.

The first heart sound is decreased in intensity when the P-R interval is long, when ventricular force is decreased as with myocardial infarction and when the first sound is "masked" by the murmur of mitral regurgitation.

7. Some comments have been made regarding auscultatory alternans, the "opening snap" of the mitral valve, and "flow" rumbles.

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Ileostomy and Colostomy Group Formed

QT GEORGIA is being organized as a mutual aid group for all ileostomy and colostomy patients. Its purpose is to give those with ileostomies and colostomies practical and emotional help; only those people are qualified for membership.

There is no limit to the tricks and details of handling equipment, and of techniques involved in using appliances effectively. By sharing experiences, patients will learn the most effective methods and will be able to pool information which can be passed on to doctors and manufacturers. There are already

existing QT groups in Boston, New York, Philadelphia, Los Angeles, St. Paul and Miami. They discuss problems that affect their contact with other people and find it possible to work out those difficulties.

If you have patients with ileostomies or colostomies, won't you please invite them to contact one of the following: Mrs. Jane Walker, 794 Laurelmont Dr., S.W., Atlanta, PLaza 5-1366 or Mrs. Trudi Stern, 1347 Briarwood Dr., N.E., Atlanta, TRinity 5-3892.

Growth Lines Versus Fracture Lines

ALBERT B. FERGUSON, JR., M.D., Pittsburgh, Pennsylvania

DISTINGUISHING THE GROWTH line from the fracture line can be a very troublesome medical-legal problem. A knowledge of their characteristics and features in their occurrence is at times helpful.

This is illustrated in spondylolisthesis where the defect in the neural arch may be pointed out following trauma as due to the injury. The clue to the correct diagnosis is furnished by the sacrum. Ordinarily its superior border is the same width as the inferior border of the fifth lumbar vertebra. With forward slip of the vertebra, however, the sacrum builds up an anterior prominence resulting in the widening of its superior border, which would not be present if the injury were a fracture.

X-Ray Characteristics

A fracture line varies in width and has sharp angles and edges. A growth line is the same width all the way across with rounded edges.

The suture lines of a skull are growth lines. Here the line has maintained its width throughout or, if narrowing, does so in a symmetrical artistic manner, one edge of the line undulating with the other. Inspection reveals apparently sharp angles to actually be rounded or blunted.

The problem of distinguishing growth lines from fracture lines is not always easy. The pull off fracture at the base of the fifth metatarsal is a good example. The shell of bone forming a separate growth center in this area can easily be mistaken for fracture unless the fundamental characteristics of the fracture line are borne in mind.

The accessory growth center at the medial or lateral malleolus about the ankle joint is similarly difficult and leads us to several additional characteristics which may be helpful. Soft tissue swelling in the area of injury helps lead the eye to the injured area, but may be simulated by ankle sprain. More important is the fact that the accessory center in combination with the parent bony area is always larger than the expected size of the part with a single growth center. In cases where for one reason or another the growth line is difficult to see, this point may assume great importance.

Some areas where separate growth centers occur normally include the lower pole of the patella where the characteristic growth line can be seen separating the apophysis from the parent bone.

Fracture Lines That Cannot Be Seen

Where the fracture line is invisible to ordinary roentgen technique, other signs must be relied upon.

The epiphyseal line fracture when little or no displacement of the epiphysis has occurred is one of these. It must be recognized that the epiphyseal line fracture occurs on the metaphyseal side of the line and always takes with it a triangle of metaphyseal bone, however small.

Where the epiphyseal line appears intact, a search for this triangle of metaphyseal bone will frequently lead to the diagnosis which otherwise might be missed. Where epiphyseal displacement is marked, there is no diagnostic problem—in these cases the triangular area of metaphyseal bone can be seen. Common areas for this type of fracture are the distal radius and the lateral condyle of the humerus. In either case the soft tissue swelling and slight elevation of the metaphyseal cortex may be the only leads.

In infants where the growth center for the epiphysis has not yet been seen, the diagnostic problem becomes even more difficult. Epiphyseal line fractures at this time of life are frequently called dislocations if seen early before a calcifying callus is seen, or bone tumors when seen late with a massive and apparently wild growth of bone engulfing the metaphyseal area.

The reason for the appearance of dislocation is obvious. The metaphysis and diaphysis of the involved bone no longer have the expected anatomical relationship to the joint. The epiphysis, however, remains in the joint, the fracture allowing the remainder of the bone to displace away from it. The small triangle of metaphyseal bone will be present, however, still attached to the epiphysis. Knowledge of the weakness of this area as compared to the possibility of dislocation helps and will prevent useless manipulation to reduce the joint. Such fractures surround themselves with such exuberant callus that rapid remodelling in the presence of good general limb alignment tends to obliterate all evidence of the fracture. The displacement into varus or valgus

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Presented at the 1956 Annual Session of the Medical Association of Georgia, Atlanta, May 13-16, 1956.

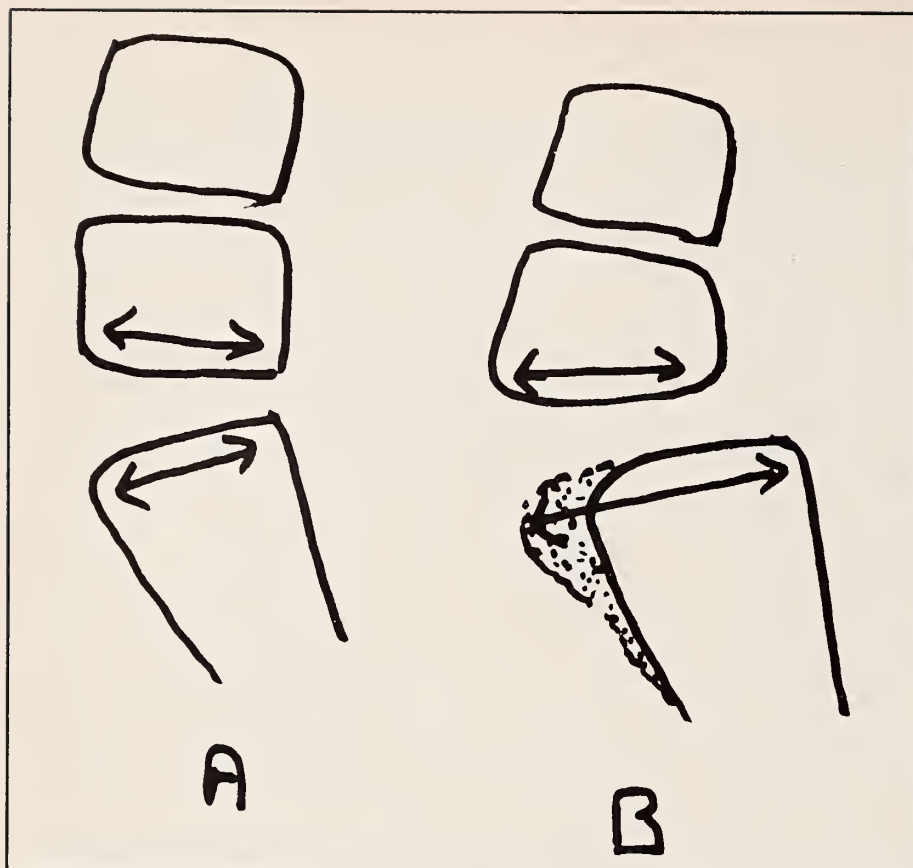


Figure 1

at either side of the knee joint may be troublesome, however, and require several years to recover normal alignment.

The two most common situations in which this injury is mistaken for dislocation include the elbow and hip.

Multiple Trauma

The child or infant subjected to multiple trauma may give rise to a diagnostic problem in distinguishing fracture lines. Such a child has usually been the victim of malicious or unconscious roughness, not once but many times on the past. The exuberant callus in remodelling has widened the bone in areas affected. More recent fractures exhibit irregular ossification about the metaphyses—with the acute epiphyseal line injury perhaps showing no more than the triangle of metaphysis and the appearance of dislocation. Subperiosteal ossification along the shaft is also frequently seen.

Most metaphyseal areas and the ribs may be involved in these patients, and roentgenograms of the upper extremity when this entity is suspected in the lower may lead to the diagnosis.

Summary

All of these situations have been diagnostic traps in the practice of medicine. The accessory growth center has been mistaken for a fracture fragment. The epiphyseal fracture has been missed in the older child. In the infant it has been diagnosed as dislocation before the appearance of reparative callus and

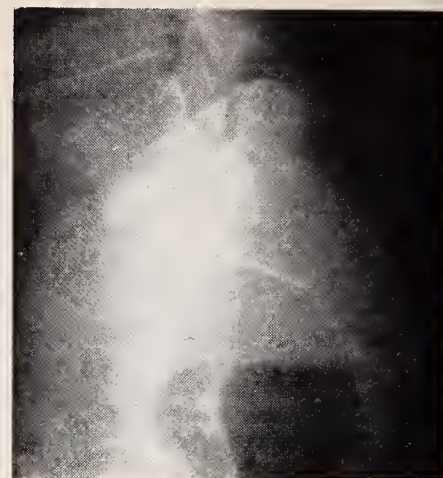


Figure 2

Anterior build up at first sacral visible by roentgenogram in spondylolisthesis.

Figure 1

Diagram of the anterior build up of bone at the first sacral vertebra in spondylolisthesis. A. Measurement of the inferior border of the fifth lumbar and superior border of the first sacral is ordinarily the same. B. In long standing spondylolisthesis the superior border of the first sacral is increased in length by supportive build up of bone.

as bone tumor after the appearance of exuberant ossification. Multiple trauma has been mistaken for metabolic bone disease and bone tumor.

The diagnostic points that have been particularly emphasized as aids in avoiding these pitfalls include:

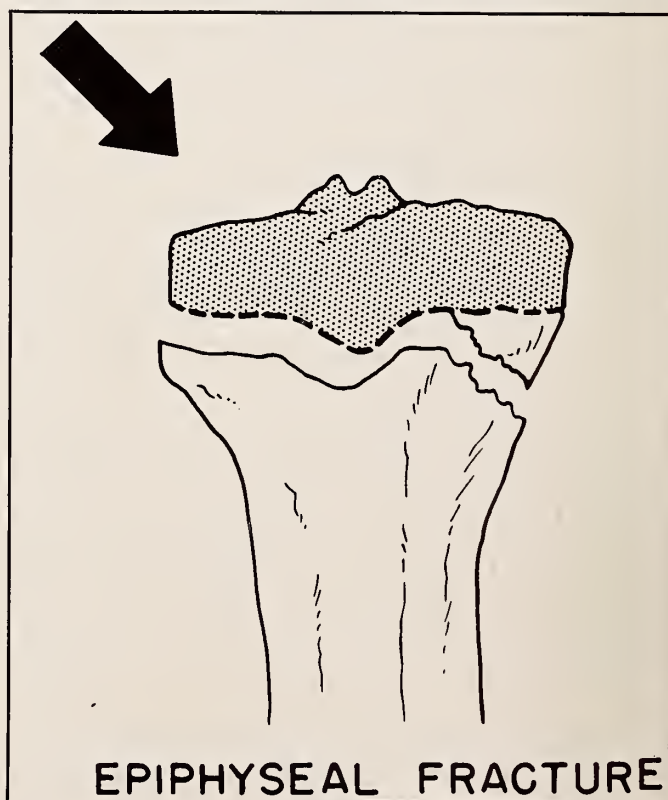


Figure 3

Diagram of epiphyseal fracture with fracture taking place on metaphyseal side of epiphyseal line and taking with it a small triangular fragment of metaphysis.

**Peculiar situations in which fracture lines
are not readily recognized are not commonly known.
The author discusses several such situations.**

(1) the varying width and sharp angles of the fracture line by comparison with the even width and round angles of the growth line, (2) the fact that accessory growth centers combine with the parent part to make the unit larger than expected if the part were growing from one center only, (3) the characteristic triangle of metaphyseal bone pulled off in epiphyseal fractures, (4) the appearance of infantile epiphyseal fractures simulating dislocations, and (5) the appearance of multiple trauma in children with widening of the bone and irregular ossification in early repair.

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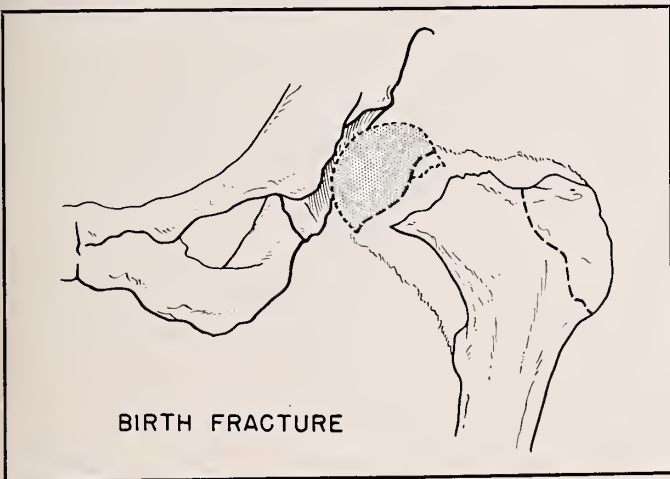


Figure 5

Birth Fracture at the hip. The part shown in zippotone is not visible on the X-Ray. This results in apparent appearance of dislocation. The small triangle of metaphysis or ossifying repair reaction gives a clue to diagnosis.

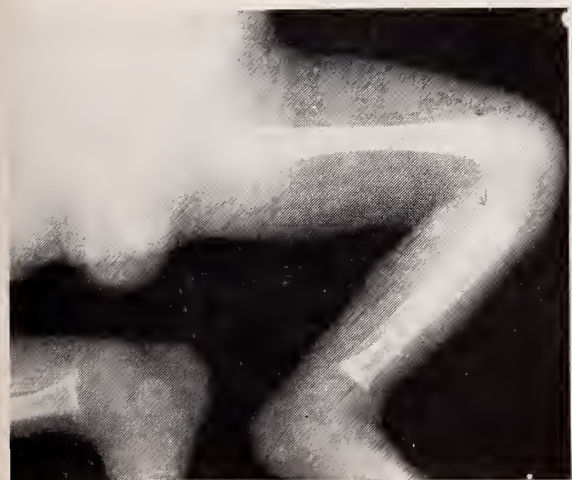


Figure 6

Multiple trauma in an infant. Small areas of metaphyseal detachment associated with epiphyseal fractures at distal femur proximal tibia and distal tibia of otherside are indicated by arrows.

Figure 4

Fracture of distal tibial epiphysis with posterior displacement of epiphysis taking with it a small triangular fragment of metaphysis.

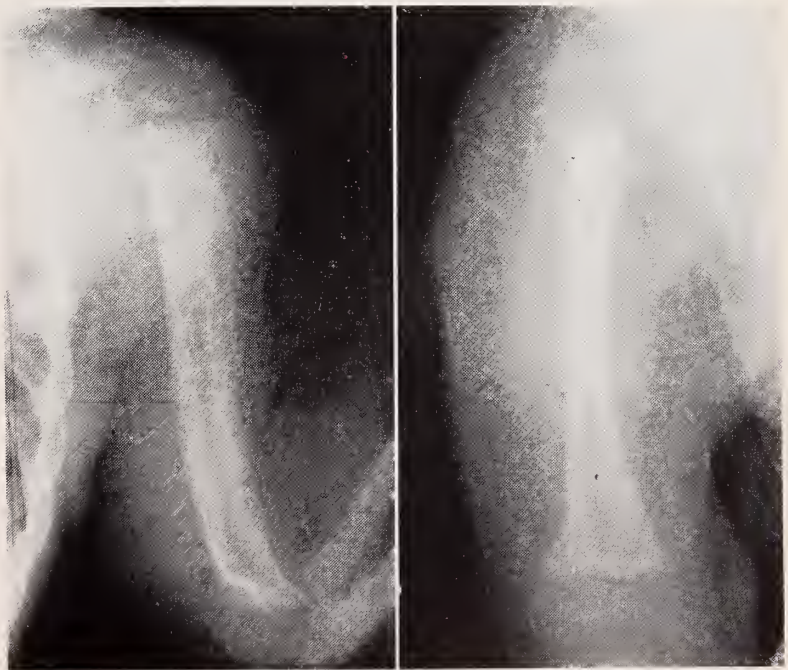
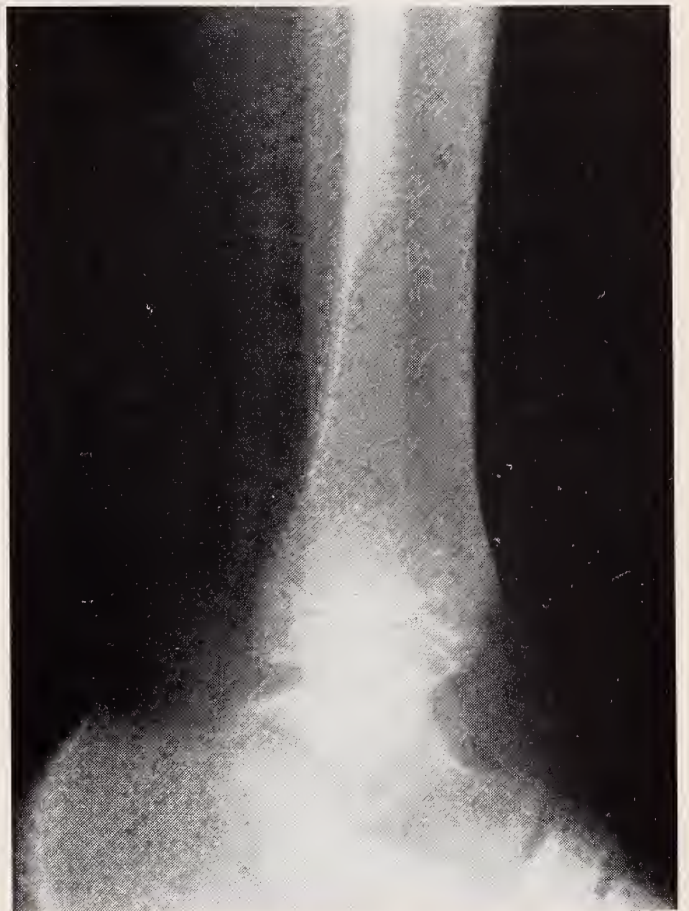


Figure 7

Widening of bone due to repeated trauma with subperiosteal hemorrhages is shown in the humerus at left. The femur in the same patient with multiple trauma has healing fractures of proximal and distal epiphysis.

Vagus Nerve Action in Pulmonary

OSLER A. ABBOTT, M.D., WILLIAM E. VAN FLEIT, M.D., ARTHUR T.

PULMONARY EMPHYSEMA of the hypertrophic type is a common and distressing disease. The name itself is misleading. We feel it would be more descriptive and informative if we called the disease "progressive obstructive distensive pulmonary atrophy." Except for the increase in the overall size of the lung, the disease is fundamentally characterized by a loss of substance and function. Until recent years there has been little knowledge or interest in the early stages of the disease — the stages whereat a physiological disturbance can be altered before permanent loss of substance and function. There is a peculiar apathy amongst physicians in regard to diseases whose terminal stages are predominantly characterized by degenerative and atrophic changes. Certainly some degree of emphysema can be expected in old age — the more benign and senile form of the disease. It is difficult to understand the limited response in men of medicine to the challenge of premature aging of a single organ system.

Pathophysiology

The most significant clinical feature of the disease is dyspnoea. However, the medical history of these patients emphasizes cough and wheeze. To us this denotes an interaction of increased bronchial irritability and some type of irritation. One cannot escape an appreciation of the severe deleterious role which tobacco plays in the production and progression of this disease. Industrial hazards and severe air pollution are other external sources of irritation. Infection in the form of chronic bronchitis constitutes a prime source of irritation. The bronchial tree in this disease is highly sensitive and overly contractile. When seen through the bronchoscope the bronchi, and in some instances the trachea, become completely occluded during the act of cough. The striking clinical feature in regard to ventilation is the delay and prolongation of the expiratory phase of respiration. The delay in air evacuation of the lungs is strikingly seen on fluoroscopic examination.

From the physiological standpoint, the impressive features are: (a) decreased ventilation; (b) prolongation expiration; (c) increase in residual air; (d) normal or elevated pulmonary artery pressure at rest which rises significantly on exercise; (e) increase in the work load of the right ventricle; (f)

decreased efficiency of the lung as shown by decreased values of pulmonary arterio-venous (A-V) differences in O_2 and CO_2 content; (g) secondary thickening of the pulmonary arterial vessels; (h) progressive loss of the finer components of lung tissue such as alveolae, capillaries, arterioles and bronchioles; (i) loss of elastic tissue and elastic recoil of the lung; (j) secondary effects upon the chest wall — widened intercostal spaces; (k) marked enlargement of the lung produces increased antero-posterior (A-P) diameter of the chest or severe downward displacement of the diaphragm or both.

Incidence

The disease is common and seen about four times more frequently in the male than in the female. Of major importance is the frequency with which this disease is seen below the age of 50 years. In our personal study group of over 600 patients with this disease, approximately 40 per cent of the patients are under 50 years.

Etiology

In general, the cause of this disease has been considered obscure. Our studies¹⁻⁷ have suggested to us that there may be some inherited weakness of the bronchopulmonary system in that 49 per cent relate a significant family history of chronic lung disease. Bronchial irritation and increased bronchial irritability over a prolonged period of time are related by more than 90 per cent of the patients. Evidence of bronchospasm can be demonstrated in 95 per cent of the patients and has been present at some time in significant degree in all patients. It is our concept that intermittent complete occlusion of the air passages by cough and continuous partial occlusion by bronchiolar spasm increases the air pressure and residual air within the alveolae. In addition to distention and disruption of the alveolus this produces significant disturbances in blood flow through the lung — both by direct mechanical action and reflex mechanisms which produce atrophic degeneration of the lung and serious disturbances in respiratory physiology. To better understand this mechanism, it is of value to consider the interdependence and interregulation of multiple circulations within the same organ system. We are familiar with the effect of disturbances in the circulation of the spinal fluid upon cerebral blood flow. The interdependence of blood and lymph flow in the lower extremities is repeatedly observed. The interaction of the multiple circulations, namely the systemic

* From the Division of Thoracic Surgery, Department of Surgery, Emory University Clinic and Emory University School of Medicine. Presented at the 1956 Annual Session Medical Association of Georgia, May 13-16, 1956.

Emphysema of the Hypertrophic Type

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arterial, the portal venous, and the biliary system in the liver, again exemplifies interdependence and interaction of multiple circulations in the same organ system. In the lung, we are faced with two different arterial systems; lymphatic circulation and another major circulation — namely that of air through the tracheo-bronchial tree. This interaction consists of direct effects of one circulation upon the other, as well as nerve reflex arcs and chemical control mechanisms. It appears that a significant general principle is that “continuous partial and intermittently complete obstruction of one of an interdependent pair or group of circulations within a single organ system produces decreased or less efficient flow in the other circulations.”⁴ If such a situation is sufficiently prolonged the host organ must of necessity undergo changes which we classify as atrophy or premature aging. If this hypothesis is correct, then the treatment or eradication of the disease must incorporate eradication of the sources of bronchial irritation, or decrease in bronchial irritability, or both.

Classification of Disease Relative to Stage and Disability

Our early work on the ventilation aspect of the problem soon impressed us with the need for classifying patients with hypertrophic emphysema according to the stage of the disease in which they were found and the degree of disability presented. We reviewed an initial series of 292 patients with the disease and presented a classification of stages which incorporated an understanding of the etiology and progress of the disease. Furthermore, there is an attempt at a distinct correlation between the stage of the disease and the treatment program required.

STAGE I: Thus we feel that the first stage is one in which there are purely physiological disturbances without secondary permanent anatomical tissue damage. At this time, we see bronchial irritation and irritability, bronchospasticity, expiratory obstruction, increase in residual air, decreased ventilatory capacity without true tissue change either in regard to the alveolus or the wall of the pulmonary arteries. Elimination of the bronchial irritant either in the form of tobacco or bronchial infection should restore a normal physiology of respiration. Oftentimes it is necessary to decrease bronchial irritability also by use of parasympathetic nerve blocking agents. This is the stage of the disease where it

should be diagnosed and the greatest therapeutic good accomplished. This means we must attend to chronic cough and minimal decrease in respiratory reserve. At this stage dyspnoea is usually purely subjective and almost at a subconscious level.

STAGE II: On study of serial x-ray films over a period of years on individuals with this disease, we have been impressed with the tendency for the initial tissue destruction to be localized in one portion of either one or both lungs. This localized origin often leaves its mark so that as the disease becomes more generalized and widespread, this original area will present as the area of most extensive damage. It is also important to note that this localization tendency is not necessarily a purely anatomical situation. Thus a patient may describe a subjective sensation of greater disability on one side. In addition, in episodes of lessened bronchial irritation and irritability, a significantly greater delay in air evacuation of a single lung can be noted at fluoroscopy. In Stage II then, we have progressed to actual permanent tissue damage, but it has a distinctly localized character both anatomically and physiologically. Local atrophic disturbance without secondary generalized pulmonary arterial change is presented.

STAGE III: In this stage the disease is generalized and major secondary vascular changes become progressively apparent. The excursion of the chest wall becomes less extensive as this stage progresses. The diaphragms descend, their movement becomes increasingly restricted, and the attachments of the diaphragm to the chest wall may be seen at fluoroscopy during full inspiration. The latter part of this stage constitutes the so-called “fixed-type” of disease. The physiological response of the patient changes as this stage progresses. In Stage I, II, and early Stage III, the bronchospastic state can be easily demonstrated by the major beneficial changes in ventilation producible by broncho-dilating drugs. This variance in response to bronchodilators, according to the stage of this disease, needs considerable emphasis. Studies in regard to the action of these types of drugs in relation to hypertrophic emphysema are confusing and inadequate unless due cognizance of this phenomenon is revealed by the investigator.

Classification of Disability

The stages of the disease are revealed by detailed study of inspiration-expiration roentgenograms and fluoroscopic studies of ventilation. We feel there

may also be benefits in classifying the disease as presented by individual patients according to the degree of disability presented and the response which may be obtained by intensive non-surgical therapeutic measures. This is a distinct parallelism to the classification applied and found useful by the American Heart Association⁸ relative to cardiac disability. Thus we classify Class I as patients who are asymptomatic, but in whom radiological studies and laboratory pulmonary function investigations would reveal prolongation and decreased completeness of expiration often of a localized character and increased residual air. Even on major stress the decrease in pulmonary reserve may not be noted and then essentially as a subjective complaint. In Class II the degree of loss of pulmonary reserve becomes apparent, objectively and subjectively, under moderate stress, when the underlying condition is aggravated by an active exacerbation of respiratory tract infection. Between such attacks an apparent normalcy of respiration and respiratory reserve is presented. In Class III, a distinct deficiency of respiratory reserve is present at all times, but symptoms are markedly relieved or almost eradicated by proper intensive medical measures (compare recurrent cardiac failure under minimal stress controlled by medical measures in Class III heart disease). Finally in Class IV, the disability is becoming increasingly pronounced and more refractory to therapy, so that some degree of "pulmonary failure intractable to adequate therapy is presented. Actually in Class IV pulmonary emphysema the thickening of the walls of the pulmonary arteries and the high resistance to pulmonary blood flow play a major role in producing the Class IV state (not unlike that seen in the Class IV patient with rheumatic heart disease). Cor pulmonale is seen in late Class IV pulmonary emphysema. These remarks relative to the stages of pulmonary emphysema and classification of disability are made to emphasize: (a) the progressive nature of the disease, (b) the challenge that earlier recognition of the illness should lead to a greater degree of salvage with less intensive measures, and (c) that certain physiological responses to drugs, denervation, and other therapeutic measures will differ according to the stage and class of disability presented.

The Functions of the Pulmonary Autonomic Nervous System

It is well known that there is a variance in the function of the pulmonary autonomic nervous system in different species. There is, therefore, a distinct danger in transferring data relative to this nervous system from the experimental animal to man. Further direct studies upon the human are desirable. At present, we do have sufficient data to indicate that the vagus nerve controls bronchial sen-

sations and sensitivity as well as producing bronchial and bronchiolar contraction.⁹ Adequate data relative to the effect of stimulation of the vagus or sympathetic nerves upon pulmonary arterial pressure and pulmonary blood flow are not yet available. The sympathetic nervous system probably has no sensory component relative to the bronchial tree, but may transmit pain from the pulmonary arteries. These nerves are also considered to relax the bronchial and bronchiolar musculature. In regard to the bronchial glands, the vagus nerves act to dry secretions.

Evidence Indicative of the Role of the Vagus Nerve in Pulmonary Emphysema

It is of interest to note that the hypertrophic type of emphysema can be best produced in the experimental animal by exposure to small dosage of phosgene gas.¹⁰ This substance acts as a violent stimulator of the parasympathetic nervous system. For many years it has been common practice to use parasympathetic nerve blocking agents or sympathicomimetic drugs for symptomatic relief of dyspnoea and bronchospasm in pulmonary emphysema. Because of this knowledge we embarked upon an investigative program relative to the role of the vagus nerve in this disease 10 years ago.

Objective Data Relative to the Role of the Vagus Nerve in Pulmonary Emphysema

We utilized three basic methods in regard to the study of reaction of the autonomic nervous system in relationship to the hypertrophic type of pulmonary emphysema. Actually a considerable number of the studies^{7,11} have dealt with other types of diseases in an attempt to define the role of the autonomic nervous system relative to both ventilation and its action in regard to the control of the lesser circulation. The data from this last study has provided useful material suggesting the normal behavior of the autonomic nervous system to which the actions noted in pulmonary emphysema may be compared or contrasted.

Effects on Ventilation: Our studies in regard to ventilation are admittedly incomplete at this time and much detailed further work in regard to this aspect is both needed and planned.

Effects on the Maximum Breathing Capacity: It has been stated that the normal patient will not show an increase in maximum breathing capacity of more than 10 per cent as a result of drugs classified as bronchial relaxants.¹² Confusion in regard to the effect of these drugs in pulmonary emphysema exists in large part, we feel, because reports have not differentiated clearly between the type of emphysema (bullous, mixed bullous, and hypertrophic or pure hypertrophic). When the pure hypertrophic type is

involved, classification relative to stage or degree and disability has not been specified. Our studies now include a group of 150 patients. We feel that there is a significant response of maximum breathing capacity in all patients with hypertrophic emphysema with Class III disability. The maximum breathing capacity is seen to increase from 18 to 94 per cent. As one descends into Class IV and approaches the fixed stage of the disease, the response of maximum breathing capacity to parasympathetic nerve blocking agents becomes progressively less marked. In the fixed stage of the disease it is not uncommon to see no significant response to such drugs in regard to maximum breathing capacity. Our studies have included the effect of several drugs which are considered to have the capacity to block the functions of the vagus nerve. The drug study, to date, includes aminophyllin, banthine, probanthine, Malcotran, and antronyl bromide. The effect of stimulation of the sympathetic nervous system by adrenalin has also been investigated, and the results in the main are very similar to the effects obtained from drugs acting to block the action of the parasympathetic nervous system. A comparative study of the efficiency of the various drugs mentioned is in progress. These drugs all appear to have a similar atropine-like action and in comparison to date have not shown a significant difference. In all instances the drugs have been administered intravenously in this study group.

Bronchspirometric Studies

In a small group of patients, bronchspirometric studies have been performed. In these patients, baseline evaluation of the individual ventilatory capacity of each lung, at rest and during exercise, are evaluated. These studies are then repeated after the intravenous injection of various drugs having an atropine-like action. In some instances such studies have been performed after the patient has recovered from some type of pulmonary denervation procedure. Data in this regard show that again response varies with the stage and degree of disability of the disease presented. In patients on whom extensive dorsal sympathectomy alone has been performed, and who have hypertrophic type pulmonary emphysema, the injection of parasympathetic nerve blocking agents produces a significant increase in tidal air, vital capacity, and oxygen consumption. An interesting finding in the group of patients who have had previous complete vagectomy to one lung, atropine-like drugs produce no change in this lung in regard to tidal air, oxygen consumption, or vital capacity; while the contralateral lung with intact vagal innervation will show significant increase in all these factors. This test, therefore, could also be of some usefulness in determining the completeness of vagotomy performed.

Studies Relative to Residual Air: We do not as yet have sufficient data to present relative to the effect of vagus nerve blocking agents or actual vagectomy upon residual air in hypertrophic type of pulmonary emphysema. This is an extremely significant aspect of this work. We do, however, have certain suggestive evidence in this regard. George Wright¹³ showed that there was a significant correlation between timed inspiration-expiration chest roentgenograms with measurement of the lung area portrayed on the two films and actual laboratory studies relative to residual air. We have been considerably impressed with fluoroscopic studies relative to pulmonary emphysema prior to and after administration of parasympathetic nerve blocking agents and we also have studied the effect of unilateral pulmonary vagectomy upon the comparative speed and completeness of air extrusion during expiration. Again we note some correlation to the stage of disease and classification of disability presented. In the majority of instances when a patient with moderately severe (Class III), hypertrophic pulmonary emphysema is subjected to a unilateral complete vagotomy, the increase in the speed of air evacuation during expiration on the denervated side is sufficiently increased that the mediastinal structures will move towards the operated side often as much as three to seven cm. Roentgenological recording of these phenomena by inspiration-expiration x-ray films, as well as by cinefluorography, are in progress. This phenomenon of increase in the speed and amount of air extrusion from an emphysematous lung after a pulmonary vagotomy has remained demonstrable in a significant degree in patients as long as nine years after denervation. These findings would suggest that obliteration of the function of the vagus nerve decreases residual air in patients with the hypertrophic type of pulmonary emphysema.

Studies Relative to Pulmonary Vascular Dynamics

Studies have been performed relative to the effect of parasympathetic nerve blocking agents upon the pulmonary artery pressure at rest and after exercise in a group of 65 patients with pulmonary emphysema of the hypertrophic type. These patients were studied in the conscious state with the intact chest by venous cardiac catheterization of the standard type. The phenomenon originally described relative to pulmonary artery pressure and pulmonary emphysema was confirmed.¹⁴ Here, according to the stage in which the disease is encountered and the classification of disability, one may find that the pulmonary artery pressure may be either normal or elevated at rest. A significant elevation of pulmonary artery pressure is seen on exercise in all patients with this type of emphysema. After the in-

jection of parasympathetic nerve blocking agents the resting pulmonary artery blood pressure will drop towards normal levels except in late stages of the disease where considerable secondary degenerative processes have occurred in the pulmonary vascular bed.⁷ In a similar manner, the rise of pulmonary artery pressure upon exercise may be partially or completely inhibited by such drugs in the less terminal stages of the disease. It is particularly impressive to see the tendency of such drugs to decrease the diastolic pressure in the pulmonary artery, suggesting that a decrease in resistance to blood flow has been produced. Our control studies relative to this comparatively large series of cardiac catheterizations on patients with pulmonary emphysema are significantly limited — actually to only one patient with a normal pulmonary status. We do know that there are several diseases in which pulmonary artery pressure may be elevated at rest and rise further on exercise. Thus we will see such changes in diseases with increased pulmonary resistance such as pulmonary fibrosis¹⁵ and also in diseases with pulmonary congestion and increased blood flow such as in atrial septal defects.¹⁶ The effect of vagus nerve block in pulmonary fibrosis has not been striking in three personal cases.

Studies on the Effect of Direct Unilateral Vagus Nerve Block and Intervenuous Atropinelike Substances Upon Pulmonary Artery Pressure

In this group, 47 patients were studied at the time of open thoracotomy in regard to the effect of direct novacaine block of the vagus nerve going to one lung upon the pressure within the exposed pulmonary artery at different levels of intratracheal ventilatory pressure. A significantly different response was noted in patients with pulmonary emphysema in comparison to patients being operated upon for 14 other types of thoracic disease. In the essentially healthy lung, pressure within the pulmonary artery tends to exactly parallel the pressure delivered by the anaesthesia respirator into the trachea. No significant effect of vagus nerve block is produced in non-emphysematous patients except for a definite tendency to increase the diastolic pressure in the pulmonary artery. In patients with pulmonary emphysema of the hypertrophic type, there is a significant tendency toward a marked elevation of pulmonary artery pressure in response to increasing the delivered intratracheal ventilatory pressure. In late stages of the disease a very significant increase in pulmonary resistance is produced, such as to decrease blood return to the left ventricle and produce significant drop in systemic arterial blood pressure. When this phenomenon is seen in less fixed stages of the disease, it can be partially or completely obliterated by direct novacaine block of the exposed

vagus nerve. In late or fixed cases, this deleterious response can only be corrected by dropping the intrabronchial ventilatory pressure to normal levels. Again in this group of patients we see a significant tendency for vagus nerve block to drop an elevated pressure in the pulmonary artery to normal levels and to decrease inordinately high elevations in the pulmonary artery pressure in response to increased intraventilatory pressure. The tendency to drop the diastolic pressure in the pulmonary artery, both at rest and on exercise, is again seen. We see, therefore, a significant correlation between the studies of pulmonary artery pressure during thoracotomy with an open thorax in response to increases in the level of the delivered intratracheal ventilatory and the rather similar changes produced in patients undergoing cardiac catheterization in the conscious state with an intact chest in response to exercise. In both instances, more strikingly beneficial effects are obtained by vagus nerve block before major secondary changes in the pulmonary vascular bed have occurred.

Studies Relative to Pulmonary Venous Pressures in Patients at the Time of Thoracotomy

This study is a relatively new one and is not as yet completed. Initial investigation would suggest that again we will see a specific pattern in patients with hypertrophic emphysema in contrast to a fairly standard response in patients being operated on for other types of intrathoracic disease. The results of these studies will be reported at a later date.

Studies Relative to A-V Differences in Oxygen and CO₂ Content

This study has incorporated investigation in two categories. Studies in regard to pulmonary artery-pulmonary vein differences in oxygen content and CO₂ content at the time of open thoracotomy in different diseases has recently been reported by us.¹¹ Again we find a specific pattern in patients with pulmonary emphysema not seen in eight other disease entities studied. Varying with the stage of the disease encountered one sees a significant improvement in the pulmonary artery-pulmonary vein difference in oxygen and CO₂ content in response to direct block of the vagus nerve or to unilateral complete vagotomy. Comparing this response with the effect produced in the systemic A-V difference shows that the change is confined to the one exposed denervated lung. It is of marked importance to note that very significant changes in a useful direction have been accomplished even in the very late stages of the disease wherein the patient has also shown cor pulmonale prior to surgery.

A more recent aspect of this type of investigation involves the study of the systemic A-V difference in

O₂ and CO₂ content in the conscious patient with the intact chest. Studies in this regard are somewhat limited at this time, but a definite pattern is again being presented. These studies have been confined, however, to people with the hypertrophic type of pulmonary emphysema. There appears to be a significant correlation between the response of the patient's ventilatory studies to parasympathetic nerve blocking agents and the degree of change on the systemic A-V difference. In this group of patients a baseline study is performed one day by obtaining femoral artery and femoral vein blood samples at rest and during exercise. On the following day the same studies are repeated under the influence of intravenous dosage of a parasympathetic nerve blocking agent. In less terminal cases the oxygen content of the femoral artery at rest and on exercise is higher after administration of the drug. In parallel manner the CO₂ content of the arterial blood tends to decrease. In several instances the patient has been able to complete the full three-minute exercise test only after injection of a parasympathetic nerve blocking agent.

Clinical Considerations

We have now accumulated detailed personal experience with more than 650 patients with hypertrophic type of pulmonary emphysema. Throughout this study we have become increasingly impressed with three major factors. First, the disease certainly occurs in a large number of patients below the age of 50 years. Second, there is a significant correlation between the use of tobacco and this disease. A very significant improvement in regard to symptoms can be obtained in many patients purely by making them desist totally from the use of tobacco. Persistence in the use of tobacco will, in the main, obviate or significantly retard any clinical response whether the therapeutic program be non-surgical or surgical. Third, there is a significant tendency for the medical profession to recognize this disease only in its late stages.

This paper does not tend to deal with the method of therapy utilized except insofar as clinical experiences may reveal to some degree the role of the vagus nerve in this disease. In our experience, at least 90 per cent of the patients show a significant degree of bronchospasticity and obtain clinical benefit from adequate dosage of a parasympathetic nerve blocking agent type of medication. In patients in whom pulmonary vagectomy of complete type has been performed, significant subjective and objective improvement has been obtained. In the earlier days of this study when some patients were subjected purely to complete pulmonary sympathectomy, true objective benefit did not result.

As is so often the case in autonomic nerve sur-

gical procedures, the early results were confused by the performance of inadequate and incomplete denervation procedures. The so-called pulmonary plexectomy described by Blades¹⁷ has not, in our experience, maintained a sufficiently high instance of objective evidence of longstanding complete vagotomy. This was particularly noticeable on patients undergoing a left pulmonary plexectomy. In such patients, an approximately 95 per cent instance of return of some contractility and sensitivity of the left mainstem bronchus was noted in patients who were bronchoscoped one or more years after the operation. It is now our practice to totally transect the vagus nerve just below the level of the recurrent laryngeal nerve on the left. The ligamentum arteriosum is transected and the aortic arch partially mobilized, and from five to seven branches of the vagus nerve going directly from the recurrent laryngeal nerve to the left mainstem bronchus are then identified and transected. To our knowledge, the presence of these nerves has not been previously recorded, and we feel that their significance in regard to completeness of pulmonary vagotomy is obvious. On the right side the vagus nerve is transected just below the recurrent laryngeal nerve, and the vagus nerve is excised from that level down to one cm. below the orifice of the right upper lobe bronchus. This extensive resection is necessary because of fibers which come across behind the carina from the left vagus nerve to meet the right vagus nerve just above the level of the right upper lobe bronchus. We are at present reserving concomitant dorsal sympathectomy (D 1 through D 7) and periarterial pulmonary artery sympathectomy to those patients in whom we know the disease has been allowed to progress to a significant degree of pulmonary artery atherosclerotic change. We often perform pulmonary vagotomy as a unilateral procedure and may not recommend its use on both sides. This is done basically on theoretical grounds in that we wish to retain a greater degree of bronchial sensitivity with a more effective cough reflex. However, in a moderate number of patients in whom the procedure has been performed bilaterally, the results have been gratifying.

We do not wish to portray the idea that the majority of patients seen by us with hypertrophic type of emphysema are submitted to surgical denervation procedures. Less than one out of five patients with this disease are being recommended for surgery by us at the present time. In all instances, an intensive trial of non-surgical measures is carried out. This attitude towards the relative place of autonomic nerve surgery in this disease will undoubtedly change as further experimental and clinical investigation data appears. The clinical response in 97 patients undergoing pulmonary denervation has been,

in the main, gratifying. In most instances, an inadequate clinical response to non-operative measures had occurred prior to recommending surgery.

We have not overlooked the factor, however, that there may be a definite psychological element in these patients. It might be well to briefly outline our approach to the emphysematous patient. First, a detailed history is obtained with particular emphasis upon investigating significant family history and the presence and types of bronchial irritants to which the patient has been subjected. An inquiry is made into the degree of bronchial irritability presented by the patient. The degree of disability is recorded. Importance is placed upon the physical examination, but the most significant objective investigation is represented by the fluoroscope. Particular interest is placed upon the contour, range of motion, and type of activity of the diaphragm. The ability of each individual lung to extrude air is closely observed with particular attention to any distinct tendency for one lung to extrude air in lesser amount and at slower speed than the other. The behavior of the pulmonary vascular bed as well as the size of the cardiac chambers are of considerable interest. After appropriate x-ray examinations, the patient is almost routinely subjected to bronchoscopy, taking particular note in regard to the irritability of the bronchial tree and to evidence of bronchopulmonary suppuration present. In the presence of infection, appropriate chemotherapy is instituted. The patient is carefully instructed in both lateral chest exercises and special exercises to improve diaphragmatic movement. Studies in regard to ventilation and pulmonary vascular dynamics are carried out in the majority of patients, and the timing of these depends upon the clinical status of the patient. We insist upon complete absence of the use of tobacco in any form. The patient will then be observed on an outpatient basis from three to six months, prescribing for him appropriate bronchodilator drugs, expectorants, chest exercises, and separation from external irritants. In patients with significant degree of chronic infection, long-term chemotherapy, particularly the sulfonamides, is prescribed. The patient is re-evaluated after three to six months with consideration for possible surgical denervation procedures if either an inadequate response has been obtained, or if the data from objective studies are particularly striking in regard to the role of the vagus nerve in the individual patient.

Summary and Conclusion

The authors have attempted to present the subject of pulmonary emphysema from a somewhat different aspect than is usually seen. Particular stress is placed upon evaluation of the role of certain drugs (or operative procedures) aimed to obliterate

the function of the vagus nerve according to the stage of the disease and the degree of disability presented. Attention has been drawn to the frequency with which this disease occurs in a pre-senile form prior to the age of 50 or 60. The significant tendency for the medical profession to recognize only the late stages of this disease is emphasized. Studies in regard to ventilation, pulmonary vascular dynamics and A-V differences in O_2 and CO_2 content of both the pulmonary and systemic circulations have been presented. Studies in regard to residual air are as yet incomplete. It would appear from the data presented that the vagus nerve with its capacity to relate bronchial sensations and to contract the bronchial tree plays a significant role in the etiology and progression of this illness. The data presented confirm the value of the use of bronchial dilating drugs and pulmonary vagotomy in patients with hypertrophic type of pulmonary emphysema.

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The Toxicity of Stilbamidine

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DRY STILBAMIDINE is a white crystalline powder which is stable in the dark. Solutions of stilbamidine are unstable, especially when exposed even briefly to light. The toxicity of decomposed solutions of stilbamidine must be distinguished from the relative nontoxicity of freshly prepared solutions.

The immediate toxic reactions following the injection intravenously of freshly prepared solutions of stilbamidine may include a fall in blood pressure, generalized formication, sweating, breathlessness, dizziness, epigastric discomfort, nausea, vomiting, salivation, incontinence of urine and feces, and a stuffy sensation of the face and eyelids. These reactions are transient in nature and may be avoided by giving the solution slowly. Concentrated solutions of stilbamidine may produce a thrombophlebitis at the site of injection.

The late chronic toxicity of stilbamidine is confined to a neuropathy of the fifth cranial nerves. Two to five months after a course of stilbamidine, progressive sensory changes of paresthesia, anesthesia, and hypesthesia may be seen.

Freshly prepared solutions of stilbamidine do not produce hepatic or renal injury when given to human beings in the usual clinical dose. Although the use of stilbamidine is not advocated in patients with poor liver or kidney function, the drug can be given safely to them. The best-known series of such patients is that of Arai and Snapper.¹ Eighteen patients with multiple myeloma were treated in an heroic attempt to influence the course of the disease. In two patients, function of the kidneys rapidly became poorer following administration of the drug. At autopsy, kidneys typical of an advanced state of multiple myeloma were found. These two patients have been cited repeatedly as evidence that the administration of stilbamidine is dangerous when liver and kidneys function poorly. The 16 patients in whom a deleterious effect was not observed are usually ignored. The dosage in these patients ranged from 2.1 to 6.5 grams, which is substantially more than is recommended for tic douloureux.

In the treatment of blastomycosis, one patient received 22.7 grams during a period of 34 months, and

another, 15.55 grams during a period of 20 months. These patients did not later show evidence of damage to the liver or kidneys.³ Another patient with pulmonary tuberculosis and amyloid degeneration of the liver contracted blastomycosis of the left side of the nose and head, for which he received 2.85 grams of stilbamidine. The blastomycosis regressed without further damage to the liver and had not recurred by the end of 13 months after the period of treatment.⁷

As far as can be determined chronologically, five deaths allegedly have occurred in the United States from the use of stilbamidine. In one patient treated for coccidiomycosis, an improperly prepared solution was used.² The second death never occurred.⁵ The cause of the third death is subject to interpretation, since two potentially toxic drugs were used. The patient had blastomycosis and was first treated with ethyl vanillate, 6.0 grams per day, for about six weeks. Subsequently, 1.3 grams of stilbamidine were given and the patient died shortly thereafter.⁶ The fourth death never occurred.⁴ The fifth patient had an infection due to *Cryptococcus neoformans*. Stilbamidine, 0.45 grams was given for four days, 0.3 grams for three days, 0.15 grams for six days, 0.45 grams for one day, and 0.3 grams for one day. The total dose was 4.35 grams given over a period of 15 days. It is not known whether the stilbamidine was toxic to this patient since an autopsy was not performed.⁸ In all, then, two deaths questionably due to stilbamidine occurred.

Stilbamidine, 0.15 grams in 225 cc. of five per cent glucose in distilled water, given intravenously slowly daily for 14 days, is a safe treatment for patients with tic douloureux. The drug must be prepared properly and administered promptly and slowly.

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Disability Insurance Under Social Security

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EVERY DOCTOR HAS PATIENTS who become disabled and have to stop work before they reach age 65 or die. Most of these patients face serious financial problems as well as the emotional problems of adjusting to their disabilities.

Until 1954 the social security law did not take this problem into account. The law was changed in that year to permit a worker to "freeze" his earnings record, on which his social security benefits are based, if he becomes disabled for any substantial gainful work. Further amendments in 1956 provide for payment of disability insurance benefits to totally disabled workers at age 50 and for continuation of a disabled child's benefits past the age of 18.

Physicians in Georgia will want general information about these provisions for two reasons: (1) they will want to advise their disabled patients of possible social security rights, and (2) they will be asked by patients to supply medical information for use in determining whether disabilities are serious enough to qualify them as "disabled" under the social security law.

Applications of disabled persons are taken by Social Security Administration district offices in communities all over the nation. (There are 12 such offices in Georgia, but service is provided by traveling representatives to every county in the State.) These offices assist applicants in securing documents and proofs but do not make disability evaluations. Determinations of disability are, in general, made by the Georgia Division of Vocational Rehabilitation under an agreement between that agency and the Secretary of Health, Education, and Welfare. The skills and established organization of the Georgia agency and the existing relationship between the agency and the medical profession are utilized.

Vocational Rehabilitation

One of the most important phases of the disability program is the emphasis it puts on the rehabilitation process. All applicants are referred for vocational rehabilitation with the hope that such referrals will result in rehabilitation programs designed to restore such applicants to gainful employment. Where it is

possible, rehabilitation is the most economical method of providing for disabled people and is, of course, the most satisfactory method for the disabled person. If a disabled worker who is otherwise entitled to disability insurance benefits is offered rehabilitation services and refuses them, his disability insurance benefits will be withheld.

Disability Insurance Benefits at Age 50

In July 1957, the OASI program will begin paying monthly disability insurance benefits to people between the ages of 50 and 65 who are permanently and totally disabled. To qualify under the requirements specified in the law, a person must be permanently and totally disabled for substantial gainful work, must meet specified requirements as to both length and recency of covered work, and must be disabled for at least six months before benefits begin. The amount of a disability benefit will be the same as his old-age retirement benefit would be if he were eligible to receive it at that time. The amount ranges from a minimum of \$30 to a maximum of \$108.50 a month, depending on the worker's earnings prior to becoming disabled. A worker's social security disability benefit will be reduced by the amount of any other disability payments to which he is entitled under the program of another Federal agency, or under a State or Federal Workmen's Compensation Law.

But not all disabled people who have been in work covered by social security for the required length of time are eligible to receive disability insurance benefits or to have their social security records "frozen." There must be medical evidence showing that he has a physical or mental impairment so severe that it prevents him from doing any gainful work, and that his disability is expected to continue indefinitely or result in his death.

Guides for Determining Disability

The right to a determination of whether a disability does or does not exist is a Federal right, although the determination is made by a State agency. Congress intended that it be made under standards and procedures that are reasonably uniform and that will afford all applicants equal treatment wherever

they reside. Guides for evaluating disability have been developed in consultation with State representatives and with the advice and assistance of a National Medical Advisory Committee.¹

These guides are intended to serve as descriptions of the level of severity of impairments that justify a finding of "disability." They describe anatomical damage, functional loss, physical and mental disorders, and other impairments in clinical terms that connote great severity. These guides are not applied mechanically. The presumptions that flow from them may be refuted by evidence that shows the individual actually did or could work despite his impairment, as when he has special vocational experience or skills. On the other hand, an individual's condition might fall somewhat short of the prescribed level of severity of any one condition, but he might have multiple impairments that, in combination, may approximate in effect the severity of a described impairment. Such cases are also allowable. Impairments that are partially disabling or are amenable to safe and acceptable treatment are not allowable bases for a finding of "disability."

On the professional team in the State agency at least one member is a doctor of medicine. In making a disability determination the team considers not only medical evidence, but also such non-medical factors as the individual's education, training, experience, and age.

How Medical Reports Are Secured

It is the applicant's responsibility to furnish basic medical evidence concerning his disability. The medical evidence needed to establish the nature and severity of his disability, the date it began and its prognosis come from the physician who has treated him and who knows his case, or the hospital or institution in which the applicant has been confined. Those of you who have already completed the medical report form for the disability "freeze" program know that it is patterned after the forms used by private insurance companies. This form is furnished for the convenience of the physician. You are not asked to certify that your patient is or is not permanently or totally disabled. You are asked only to give a brief history of your patient's impairment and to relate the clinical facts as you found them during treatment or examination of your patient. The medical report form is returned by the physician or institution to a social security office or to the State agency to avoid disclosure to the applicant or patient

¹ The members are: Dr. J. Duffy Hancock, Chairman, Louisville, Kentucky; Miss Pearl Bierman, Chicago, Illinois; Dr. Philip D. Bonnet, Boston, Massachusetts; Dr. Donald Covalt, New York, New York; Dr. Charles L. Farrell, Pawtucket, Rhode Island; Dr. J. S. Felton, Oklahoma City, Oklahoma; Dr. Herman E. Hilleboe, Albany, New York; Dr. Lemuel C. McGee, Wilmington, Delaware; Dr. Kenneth E. McIntyre, Detroit, Michigan; Dr. William A. Pettit, Los Angeles, California; Dr. Leo Price, New York, New York; Dr. William Harold Scoins, Fort Wayne, Indiana; Carroll Shartle, Ph.D., Columbus, Ohio; Br. Byron Smith, Minneapolis, Minnesota; Dr. David Wade, Austin, Texas.

and protect the doctor-patient relationship. Any information a doctor gives is, of course, treated as confidential.

As physicians, you can assist the disability program and your patient by furnishing the necessary medical reports. The evidence you furnish should be sufficient to enable a reviewing physician to make an independent diagnosis on the basis of clinical evidence supplied on the medical report. The type of medical report used is the same for children's disability and for disability insurance payment purposes as for the disability "freeze." In neither case, however, is the use of the form mandatory, for the physician is free to use the method of his choice. However, the items listed on the form furnish the physician with a guide as to the kinds of evidence needed by the State agency to make a determination of disability. By supplying the type of clinical evidence listed on the form, the reporting physician will reduce the need for additional reports which are sometimes requested when the evidence is not complete.

Where the initial medical report furnished by an applicant's physician fails to establish the severity of the impairment, the State agency may write directly to the physician for additional information. This approach has been adopted to preserve and strengthen the doctor-patient relationship. If further examination is required in order for the physician to supply the information requested by the State agency, the applicant should be informed and asked to arrange for such an examination. Whether you advise your patient directly of the need for further examination or ask the State agency to do so depends on your wishes in the matter.

Who Pays for Medical Evidence

Since the law places upon the applicant the responsibility of furnishing supporting evidence, he is responsible for paying any basic costs involved. However, a medical examination at the expense of the Government may be authorized where, in the judgment of the physician in the State agency who has reviewed all medical evidence in a case, it seems necessary to verify certain facts or clear up discrepancies to insure that an improper award will not be made.

Comments

Comments and suggestions from practicing physicians on the operation of the disability insurance program are welcome. Their opinions are highly regarded and carefully considered. Send these to the *Journal* or any social security district office. Also, the social security district office serving your community will, upon invitation, have a representative meet with any local medical group to discuss this subject in greater detail.

50 Seventh Street N.E.



Lip Service to Automobile Safety

MOST IMPRESSIVE ARE the remarks—"why should I stop smoking, my chances of getting killed on the expressway are much greater than the chance that I will die from the ill effects from cigarettes." This, a physician's statement, might be prematurely categorized as fatalism. To practicing physicians—who are in automobiles so much and frequently responsible for the care of accident victims—the quotation rapidly assumes proportions of logic. Present-day sales campaigns maintain two efforts: obviously, selling more new cars to regular customers and secondly, putting an additional car in the hands of each family. With increasing traffic mortality, it is quite questionable whether the ancillary campaign will ever be profitable. Planned parenthood organizations must beware of the effects of this onslaught on their future existence. A colleague recently mentioned that with mechanization and automation advancing at a furious rate, the mule was rapidly becoming extinct. He further speculated, however, there would always be a place for the horse and for the jackass. One questions the farmer's plans for the former, but the latter, even at present, is found in increasing numbers at the steering wheels of automobiles.

Even the casual observer will notice that the auto manufacturers' current advertising is pitched not at public safety, but *power*. Almost anyone will realize that even the simplest six-cylinder car produced will exceed, with consummate ease, the existing speed limit in any of our states. In vying for individuality associated with first place in sales, one concern has shown that two attractive young ladies can drive their car from one coast to the other in a little over two days. There are less strenuous ways of covering the distance. Another passionate need at this time apparently is to go 50,000 miles from here at a little in excess of 108 miles per hour. This latter test to prove durability of the automobile fails to demonstrate the durability of the occupant if he inadvertently skids off the road or into a utility pole at 30 miles per hour. It must be admitted that auto manufacturers can hardly be responsible for brainless drivers who invite disaster. At the same time, however, they have done precious little to protect others from his insult. Well-documented studies have been performed to demonstrate the very effective manner in which safety belts, padded dash and visor, re-

cessed instrument handles, etc., are of prime importance in protecting the occupant. But, in *most* instances this equipment is optional. Yet in the same product, magnificent, high horsepower motors, ever going higher, are included at list price. The aircraft industry has shown that padded head rests and seats facing the rear are essential for safety and are specified as such in all military air transport planes. Where are these in the automobile? Actually everyone but the driver could face the rear, avoid watching the oncoming traffic, especially at night, and thus enjoy the ride more. It must also be noted that the driver in a multiple injury incident in an automobile is usually the least seriously hurt. A third manufacturer's advertisement memorializes the hurricane of power his car unleashes. One pales at the thought of handling this with bare hands. Even more appalling is his vision of an elderly, retired couple, neither of whom would dare pick up a loaded revolver, casually cruising off in one of these dynamite-laden models. A physician appreciates that cars with all the new power equipment, which reacts so avidly to light touch, must of necessity be handled by a mature person—yes, but good vision and normal reaction time are important too. Has it ever occurred to you that with power brakes you not only can avoid accidents by stopping quickly, but you can be seriously injured or even killed at the same time by the fellow in the car behind who was too close or couldn't stop in time?

Certainly driver education is of utmost importance. But shouldn't we insist by word of mouth or otherwise that safety features be loaded into an automobile, for maximum passenger protection even at the cost of sacrificing power, speed, and high horsepower? It appears to be a necessity when one is presented with the toll of fatal accidents. Since 1900 more people have lost their lives in cars than in the past seven wars in which citizens of the United States have fought.

Diabetes Mellitus

OSLER WAS FOND of saying that to know typhoid was to know internal medicine. In the same sense, to know diabetes is to know intermediary metabolism, for the diabetic exhibits not only the varied consequences of insulin deficiency, but also those of unbalanced activity of the adrenal cortex, the anterior

pituitary, and perhaps the hyperglycemic factor of the pancreas.

Some of these consequences are listed in the following table, which is greatly over-simplified. It is noteworthy that hormonal synergisms and antagonisms vary depending on the metabolic substrate under consideration.

	METABOLISM OF		
	Carbohydrate	Fat	Protein
Insulin	Utilization increased	Anabolic and anti-ketogenic	Anabolic
Adrenal Cortex	Utilization inhibited; gluconeogenetic	? Anabolic; anti-ketogenic	Catabolic
Anterior Pituitary	Utilization inhibited	Catabolic and ketogenic	Anabolic
Diabetes	Utilization inhibited	Catabolic, ketogenic	Catabolic
Response to Hypoglycemia	Utilization inhibited	Catabolic, ketogenic	Catabolic

To proceed from such abstruse consideration to the clinical problems is really a short step. The physician caring for diabetic patients must take this mental step with every decision he makes, as can best be illustrated by three examples.

It is a clinical maxim that the new diabetic who is overweight can often be controlled by diet alone; the underweight or juvenile diabetic will always need insulin. Since insulin is an essential hormone for fat anabolism, the mere fact that a diabetic is obese implies the presence of some insulin in the body. (This implication has been borne out by recent measurements of plasma insulin levels in normal and diabetic subjects). A drastic curtailment of carbohydrate intake reduces the burden on insulin production, allows no excess for continued fat synthesis, and favors fat breakdown (with weight loss) as one source of energy. Conversely, the premature institution of insulin therapy in such patients tends to favor fat synthesis and makes weight reduction quite difficult; at the same time, the improvement in blood and sugar levels often quenches the ardor of both physician and patient for further efforts to lose weight.

The juvenile or underweight diabetic presents a different problem; here insulin deficiency effectively curtails protein anabolism and growth. No dietary manipulation will overcome this block without the administration of exogenous insulin, which is the key to successful therapy for these patients.

Since insulin has such a well known systemic fat anabolic effect, it is a little surprising that its local effect is not more conspicuous. Actually, localized fat hypertrophy occurs rather frequently; how frequently is known only to the physician who looks for it. Contributing factors are improper rotation of in-

jection sites and the customary instructions to pinch up a fold of skin and insert the needle, at an angle, into the subcutaneous tissue. Juvenile diabetics, especially, are prone to this complication; once the rounded fat hypertrophy appears and the patient learns that such tissue is relatively pain-insensitive, he tends to strike where the fat is thickest. This practice has consequences more serious than the merely cosmetic; increased local utilization of insulin renders its systemic effect diminished and unpredictable, and the deterioration in diabetic control may suggest that the disease is more "brittle" than it really is. Such a situation can be prevented or successfully handled by use of intramuscular injections only, inserting the needle to the hub into taut skin at right angles. Indeed, the change from subcutaneous to intramuscular injections will often improve dramatically the control of "brittle" diabetes where there is no localized fat hypertrophy at all.

Another feature of the table is the striking similarity between the pathological state of diabetes and the physiological response to hypoglycemia or fasting. The latter is dictated by the utter dependency of the brain on blood glucose for its normal metabolism; thus when the blood sugar falls, all metabolic pathways are shifted so as to drive it upward. Anterior pituitary factors stimulate fat breakdown, adrenal hormones inhibit carbohydrate utilization, and ketosis is usually present. This state of affairs soon reverts to normal in the healthy organism, but in diabetes it intensifies the basic abnormality. Further problems are created by the heroic attempts of patients or doctor to correct this "insulin resistance" by increasing the dose; when the physiological response begins to wane the patient becomes sensitive to the new excessive dose of insulin, develops hypoglycemia, and a vicious cycle is set up. This is a process of immense clinical significance. Peters (*Yale J. Biol. Med.* 27:152, 1954) cites insulin hypoglycemia as the most common precipitating factor in diabetic acidosis and John (*Metabolism* 4:204, 1955) suspects that many diabetics take far too much insulin. The prevalence of this phenomenon is a consequence of the widespread belief that good control demands that the urine be sugar-free throughout the day every day, and that this can always be accomplished by a single dose of long-acting insulin. These ideas are not only incorrect, but also self-defeating. Most instances of unexplained glycosuria and acetonuria in an otherwise perfect record can be linked historically with a preceding episode of hypoglycemia in one of its many guises: weakness, hunger, sweating, confusion, fatigue, "all-gone" feelings, or (at night) night sweats, nightmares, and sleepwalking. Altering the diet or insulin, by preventing hypoglycemia, will prevent the exacerbation of the diabetes; and it is often quite easy to demon-



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strate decreasing glycosuria on decreasing insulin dosage.

This somewhat paradoxical situation and others like are apt to baffle the physician who does not know diabetes. But it is hoped that the frequency of this disease so fraught with paradox will encourage him to learn diabetes—and with this knowledge, intermediary metabolism shall be added unto him.

John A. Owen, Jr., M.D.
Medical College of Georgia

Public Opinion of Georgia Physicians

THIS EDITORIAL IS DESIGNED to refresh the thinking of those members of our Association who feel depressed by third-party intervention in the practice of medicine by hospitals, insurance companies and the federal government. We are being continually warned of the above-mentioned threats and as a result we tend to lose sight of the bright side of the picture.

Newsclippings from throughout Georgia collected during the past year show that national magazine headlines like "Why Some Doctors Should Be In Jail" and "Is Your Doctor Killing You" just do not apply to Georgia physicians.

For your perusal and encouragement, please find below quotes from 10 Georgia newspapers, selected at random, to show the great love and respect felt for many of our fellow members.

From an editorial in the *Gainesville Times*, March 31, 1956:

"... Dr. Bradley Davis has devoted 33 years in Gainesville to the care of children. The lives he has saved, the mothers' worries he has stilled, the kindnesses and sympathies he has shown through those years can't be translated into mere words. ... The community feels, as a matter of fact, that any gesture, however worthy, would fall short of telling the great appreciation and love felt for Dr. Davis. ... His medical life has demonstrated that it is a combination of scientific knowledge and human understanding that makes the good doctor vital to a community."

From the *Columbus Ledger*, April 16, 1956:

"'People don't like Bert Tillery. They love him.' How true this is was demonstrated this past week when word got around that a group of men were having Dr. Tillery's portrait painted to hang in St. Francis Hospital. The response was unanimous. First—'How wonderful!' Then

a bit wistfully—'I wish I could have some part in it.' Or 'How can I have a part in it?' . . . There must hardly be a family in Columbus that doesn't bless him, his skilled hands, his great heart. . . .!'"

Editorial on the sudden death of Charles Edward Wills, Sr., in the *Washington News Reporter*, March 8, 1956:

"... a few hours later he passed away. Word of his injury and his death spread rapidly and it was impossible to realize that a man who had given so generously and unselfishly of himself to his fellow man could have been taken so swiftly from our midst.

"Throughout the day a feeling of awe was present everywhere one went. and the general conversation was indicative of the great loss this and surrounding counties had suffered as a result of the tragic accident.

"... Dr. Wills was a great humanitarian, and as a physician and a surgeon, he could have served in the finest hospitals in the nation, but he chose to spend his life in relieving the suffering and bringing renewed hope and life to the people he loved in the section of his birth. He worked tirelessly with the sick and there were none that he turned down in their hour of need. We knew him well and we don't believe he ever questioned whether he would be paid for his services, for earthly possessions or wealth meant nothing to him—the only thought that entered his mind was whether he could bring a measure of relief to the suffering."

From the *Savannah Morning News*, April 19, 1956:

"There is an unusual aura of grim finality in the death of someone who has devoted most of a long career to preserving the life and health of others. Such was most certainly the case in the demise of Dr. William Barron Crawford, Sr., who has practiced medicine here for the past 55 years . . . with all his fame and reputation, Dr. Crawford remained a modest and self-effacing man. Nor, when his medical efforts received their just material rewards, did he slacken in his lifelong program of service to that large segment of local humanity to which he ministered.

"He was justly a credit to both his honored profession and our community. In his death we have suffered a great loss."

From an article in the *Rockmart Journal*, February 2, 1956, concerning the 50th Anniversary of the medical practice of George Martin White:

"His entire life has been marked by its patience, thoughtfulness and kindness, and many a young man, just out of medical school, has

gone on to a successful practice after receiving encouragement and patient teaching from this understanding doctor.

"Dr. White has seen this city grow and has played a big part in its growth; of this he should be very proud.

"But the pride and love which he has in his heart for Rockmart and Polk County does not equal the pride and love which Rockmart and Polk County hold for him and the wishes for his complete restoration to health come from everyone who has known him."

On the retirement from practice of L. H. Shellhouse *Atkinson County Citizen*, February 23, 1956:

"It was a sad day for the people of Willacoochee and the surrounding territory, when they learned that their beloved doctor, who had served them for 45 years, was retiring. . . . He has delivered approximately 3,000 babies and his interest in them has continued through the years. When his services were needed neither weather, roads, nor color, nor financial circumstances of the patient deterred him. . . . Dr. Shellhouse is a man of high civic, moral and religious principles, and by precept and example has been in the forefront of any advancement along these lines. In his quiet modest way he has spent many hours in urging and encouraging others towards a better way of life. . . ."

Editorial on the death of John W. Good, *Cedar-town Standard*, December 22, 1955:

"He who had helped so many, was unable to help himself when his appointed time came. Such tersely epitomizes the life of a physician. Not only was Dr. Good admired as a man, but he was esteemed as a physician. His presence in the sickroom gave encouragement and confidence. There was a quietness, dignity and reverence that was seen and felt. A physician for over 50 years, he was an honor to his profession.

"Words cannot measure the gratitude of the hundreds for whom he gave his medical skill for their relief and recovery. He was a physician

in the truest sense of the word—serving rich and poor alike."

Editorial on the death of A. L. Smith, *Cochran Journal*, March 15, 1956:

"Dr. A. L. Smith, who officiated at the birth of a large portion of Bleckley County's population, passed away Tuesday night.

"Beloved as a physician, and as a friend of education, Dr. Smith devoted 25 years of his life to active membership on the Cochran Board of Education, during which time many outstanding records were achieved by the local schools.

"Until the last few months of his life he was possessed of an amazing vitality and carried a full load in his practice of medicine so long as his health permitted. Nights, Sundays, rain or or shine, he went about his rounds whenever and wherever he was needed on his mission of healing. He had practiced medicine for 50 years in Dodge and Bleckley Counties, being both a physician and registered pharmacist. . . . It is men like Dr. A. L. Smith who make the medical profession what it is today."

From a Resolution from the Board of Directors, First National Bank of Louisville, and published in the *Louisville News and Farmer*, March, 1956:

"Our minutes show that no Director was more faithful in his attendance at our monthly meetings during this 23-year period than was Dr. J. S. Pilcher. This was in spite of the fact that he was a medical doctor and an exceptionally busy one, and the fact that numerous other activities, professional, business and civic, demanded his time and received his equally faithful attention.

"His judgment and counsel were at all times sound and helpful. His genial and charming personality made our cooperation and association with him at all times a joy."

These elder members of the profession are certainly to be congratulated. Let us hope that we may continue to inspire this type of confidence in the hearts of our patients and the general public.

Tax Deductible, If

U. S. INTERNAL REVENUE SERVICE now states that your expenditures for education are deductible if they are for a "refresher" or similar type course taken to maintain the skills directly and immediately required by you in your employment or business. To be covered, an educational course should: be designated for established physicians to help them keep abreast of current developments in the profession; be of short duration; but should not be taken

on a continuing basis or carry academic credit. Not acceptable: education designed to prepare the doctor to enter a specialty.

If you travel away from home primarily to obtain "refresher" education, your expenditure for travel, meals and lodging while away from home are deductible. Not allowable: expenses for personal activities such as sightseeing, social visiting, entertaining or other recreation.

Lay Evidence of Medical Negligence

JOHN A. DUNAWAY, LL.B., Atlanta, Georgia

ON NOVEMBER 29, 1956, the Court of Appeals of Georgia by a split decision reversed a judgment of the superior court of DeKalb County in which court a physician had obtained a non-suit at the close of plaintiff's evidence.

The suit was brought by the widow of a man on whom the physician had performed operations. It was alleged that during a diagnostic operation a piece of plastic tubing was broken off in an artery and subsequently the doctor performed an exploratory operation to find the piece of tubing; but the leg had to be amputated when circulation ceased, and the lost piece of tubing was found in the amputated portion.

Non-suit was granted by the trial judge on motion of the physician's counsel that the evidence failed to show cause for action as there was no professional testimony to establish that negligence had led to the need for amputation. In reversing the case the Court of Appeals stated:

"The second operation was admittedly necessitated by the breaking of the catheter, its only purpose being to discover the location thereof and effect its removal."

It was therefore held that the charge of negligence in the way the physician manipulated the tube "was supported by evidence and should have been submitted to the jury."

This is not the first decision of our Court of Appeals that lay evidence is admissible to prove negligence of the physician. In the case of *Pilgrim vs. Landham*, 63 Ga. App. 451, the rule is stated thusly:

"What is the proper method of diagnosing a case is a medical question to be testified to by physicians as expert witnesses. Laymen, even jurors and courts, are not permitted to say what is the proper method of diagnosing a case for discovering the nature of an ailment. *Results of the diagnosis and treatment, if so pronounced as to become apparent, as where a leg or limb which has been broken is shorter than the other after diagnosis and treatment, may be testified to by any one . . . And where, measured by the method shown by medical witnesses to be negligence and*

the evidence, a bad result is shown, it is the province of the jury to say whether the result was caused by the negligence (italics author's)."

In the body of the decision after laying down the foregoing rule it was held that *Pilgrim's* case against Dr. Landham was not one of those cases where the question of negligence was one that could be determined without resorting to expert testimony; but this case pointed the way for lay testimony in subsequent cases.

On October 3, 1955, the Court of Appeals rendered its decision in the case of *Caldwell vs. Knight*, 92 Ga. App. 747. J. E. Knight was a chiropractor and was sued in the superior court of Floyd County by A. W. Caldwell, a patient, who offered evidence that immediately after having been strapped to a table and subjected to alternating pulling and stretching of his spinal column by means of a mechanical device over a 10 or 15 minute period, which was administered in the absence of Dr. Knight or any person to control, operate, or adjust the device, plaintiff suffered excruciating pain and inability to move or perform his bodily functions for a period of many days. He also offered testimony of his physician that the disability from which he suffered was the result of trauma. It was held that such testimony made a jury question as to whether the plaintiff's disability was a result of negligence of Dr. Knight in administering such adjustment and mechanical manipulation of his body, even in the absence of medical testimony to this effect.

In deciding the case the court said:

"Usually, what is the standard of care required by a physician is one concerning highly specialized knowledge with respect to which a layman can have no information. In such cases the court and jury must be dependent on expert testimony in order to determine whether the standard of care employed by the defendant in a malpractice case falls short of the required degree of care and skill so as to amount to negligence, there being no other guide. Where, however, the question does not concern a claim of negligence in diagnosis or choice in methods of treatment *but rather involves a charge of negligence in the act of administering*

Dues and Special Assessments of State Medical Associations

State	Dues	Special Assessments	State	Dues	Special Assessment
ALABAMA	\$50.00	—0—	MONTANA	53.00	—0—
ARIZONA	70.00	—10—	NEBRASKA	35.00	—0—
ARKANSAS	25.00	—0—	NEVADA	100.00	\$20.00 (AMEF)
CALIFORNIA	50.00	—0—	N. HAMPSHIRE	40.00	—0—
COLORADO	50.00	—0—	NEW JERSEY	30.00	—0—
CONNECTICUT	28.00	\$10.00 volun- tary assess- ment for build- ing addition	NEW MEXICO	70.00	—0—
DELAWARE	50.00	—0—	NEW YORK	25.00	\$10.00 assess- ment (effective Jan. 1, 1957) to be used for employees' pension fund.
FLORIDA	40.00	—0—	NO. CAROLINA	40.00	—0—
GEORGIA	25.00	—0—	NO. DAKOTA	75.00	—0—
IDAHO	40.00	—0—	OHIO	25.00	—0—
ILLINOIS	40.00	—0—	OKLAHOMA	42.00	—0—
INDIANA	30.00	—0—	OREGON	40.00	—0—
IOWA	60.00	—0—	PENNSYLVANIA	40.00	—0—
KANSAS	40.00	—0—	RHODE ISLAND	50.00	—0—
KENTUCKY	35.00	—0—	SO. CAROLINA	20.00	—0—
LOUISIANA	50.00	—0—	SOUTH DAKOTA	75.00	—0—
MAINE	35.00	—0—	TENNESSEE	25.00	—0—
MARY'D	Baltimore City members \$50 County Society members \$30	—0—	TEXAS	50.00	—0—
MASS.	35.00	—0—	UTAH	50.00	\$20.00
MICHIGAN	45.00	\$10.00 Assessment for 1956 only.	VERMONT	35.00	—0—
MINNESOTA	40.00	—0—	VIRGINIA	25.00	—0—
MISSISSIPPI	40.00	—0—	WASHINGTON	35.00	—0—
MISSOURI	25.00	\$10.00 assessment for 1957 only	WASH'N D. C.	50.00	—0—
			WST VIRGINIA	25.00	—0—
			WISCONSIN	65.00	—0—
			WYOMING	25.00	—0—

Legal Counsel Page (cont'd.)

such treatment, there are types of cases in which negligence and proximate cause may be proved by nonexpert witnesses (italics author's)."

In the body of the decision the case of *Farrah vs. Patton*, 99 Col. 41 (59 Pac. 2d 76) is quoted from as follows:

"Where, as here, recovery is sought not for negligence in making an incorrect diagnosis or in adopting the wrong standard of treatment, *but for the performance of an operation in a negligent manner, any pertinent evidence having a fair tendency to sustain the charge of negligence is sufficient to take the case to the jury (italics author's)."*

In summing up the case, Judge J. M. C. Townsend said:

"We hold here that if a defendant chiropractor, in giving a patient an adjustment, were to take a hammer and shatter his backbone with a blow, or if a surgeon in performing an appendectomy were to take a knife and unintentionally slit the patient's throat, a nonexpert jury could find such

conduct to be negligence without the aid of expert testimony to that effect . . . Construing this evidence and the inferences therefrom in favor of the plaintiff, as must be done on nonsuit, a prima facie case was made out to establish negligence in administering the mechanical treatment, and it was not necessary to prove by expert medical witnesses that the treatment was in fact unskillfully performed."

While in previous decisions the Court of Appeals of Georgia has held that the doctrine of *res ipsa loquitur* (the thing speaks for itself) does not apply in a malpractice case in this state, the court as now constituted recognizes that this rule is applicable in certain types of cases as shown above, and it is to be anticipated that as more and more suits are filed against physicians in this state and find their way to our appellate courts, the rule in this state could very well be reversed to the point that, as in the state of California, a jury would be permitted to find the doctor had been guilty of negligence in almost any type case based upon the testimony of lay witnesses.

Digitalis Intoxication

ARTHUR M. KNIGHT, JR., M.D., Waycross, Georgia

DIGITALIS INTOXICATION results from excessive dosage, too frequent administration, or neglect of early warnings. Other responsible factors include seeing the patient too infrequently, failure to determine how much digitalis has been previously given, failure to appreciate the drug's cumulative action, neglect of individual variations in susceptibility to intoxication, reliance on digitalis to neglect of other measures, forcing the drug for "intractable failure," depletion of the myocardium of potassium (by mercurial diuresis or steroids), and the use of pure glycosides such as digoxin and digitoxin which are less likely to give early warnings. Digitoxin is especially dangerous in unskilled hands because of its pronounced cumulative action and slow excretion and because the popular maintenance dose of 0.2 mg. is too much for many patients

Pharmacologic effects of digitalis include the following: increased sensitivity of the vomiting center, irritation of mucous membranes, stimulation of vagal centers, vagal action on the heart (slowing, loss of tonicity, reduced conductivity), direct action on the myocardium (increased tonicity, contractility, and irritability), and depression (sagging) of ST segments in the electrocardiogram.

Symptoms may include anorexia, nausea, vomiting, malaise, headache, weakness, visual disturbances (blurring, scotomata, colored vision), mental disturbances, and diarrhea. Almost any arrhythmia or AV conduction defect may be produced, including extrasystoles, bigeminy, auricular fibrillation, A-V nodal rhythm or tachycardia, paroxysmal auricular tachycardia with block, tachycardia due to numerous ventricular premature contractions, ventricular tachycardia, and ventricular fibrillation.

Diagnosis should be suspected in all cases on digitoxin (Cardigin, Crystodigin, Digitaline Native, Myopurin, Pasanol, Purodigin, Unitroxin) who present any of the above symptoms, arrhythmia, or block. It should be considered in cases which have been on digitalis for a long time, "intractable heart failure,"

failure with slow pulse, sudden change from totally irregular to regular rhythm (idioventricular rhythm with complete A-V block or A-V dissociation), illiterate or mentally incompetent patients on digitalis, and in the presence of circumstances favoring excessive potassium loss (excessive diuresis, vomiting, diarrhea, fistula, steroids). The serum potassium level may be normal when the cells are depleted. An electrocardiogram should be made in all cases of suspected intoxication.

The first consideration in treatment, as Withering pointed out in 1783, is to "... let it [digitalis] be stopped upon the first appearance of any one of these effects." Potassium salts may be given by mouth in doses of two to four Gm. three or four times a day in 25 per cent solution in flavored syrup; or, intravenously, 3.7 Gm. (50 m. Eq.) of KCl in 500 cc. of five per cent dextrose in water by slow drip (two hours). Promazine is useful to help control the nausea. Atropine helps abolish the vagal effect and aminophylline may help by increasing coronary flow. Arrhythmias are treated in the usual way (with such drugs as quinidine, procaine amide, neostigmine, mecholyl) and with the usual precautions, but quinidine and pronestyl should be avoided with high grades of block or with idioventricular rhythm. Magnesium salts will abolish extrasystoles, bigeminy, and ventricular tachycardia due to digitalis. Rest, oxygen, vasopressor agents, and other supportive measures should be used as indicated.

To prevent digitalis intoxication, the physician must become familiar with the pharmacology and toxicity of the available digitalis preparations and tailor the digitalizing and maintenance doses to the individual patient, avoiding "average" doses. He must be conservative in regard to doses and rate of administration, avoiding digitoxin unless he is skilled in its use. He should avoid rapid digitalization whenever possible. He should never give digitalis until he has exhausted every possible effort to learn how much of it the patient has had in the past month.

Prepared at the request of the Committee on Professional Education of the
Georgia Heart Association.

month in washington

THE BROAD ISSUE of federal construction grants for medical schools pending before the 85th Congress raises again a major question: To what extent is there a physician shortage in the United States?

The administration, through Secretary Folsom, maintains that the need for more doctors and research scientists is increasing rapidly as the population rises, as medical science grows more complex, and as research programs are greatly expanded. And, he adds, the need undoubtedly will continue to increase in the years ahead.

Many of these schools already are in a critical financial plight, Mr. Folsom argues, and they need increased private and public funds "just to meet regular operating expenses." Under these circumstances, without further aid, "many schools face almost impossible obstacles in raising funds for construction of new classrooms, laboratories and other facilities." The Secretary then sounds this warning: "Unless effective action is taken now toward providing these facilities, the shortage of medical scientists will grow much more acute in the years ahead, and the health of the American people will be retarded."

To solve this problem, the administration wants to broaden the program enacted last year for \$30 million a year for three years to help build and equip laboratories doing research in various diseases. It asked the last Congress for \$50 million a year for five years for both research labs and teaching facilities. The legislators only granted the \$30-million-a-year part. That, says the administration, is not enough.

And to bolster that contention, Mr. Folsom cites the record on the lab facilities act: within three months after authorization, requests totalling well over \$100 million were received by the Public Health Service.

But when the committees of Congress — in all likelihood starting with the House Interstate and Foreign Commerce group — launch their hearings, members will want to know just how short the country is of doctors and whether reports of shortages take into account the increased productivity of each

physician in the light of new techniques and other medical advances.

Health Legislation

On the opening day of the 85th Congress, health legislation emerged as a popular subject. Of the approximately 1,000 bills, resolutions, and private measures introduced that day, 70 were marked for study by the Washington Office of the American Medical Association. Experience has shown that about three per cent of all measures are of medical importance.

Many of the bills were duplicates of those in the last Congress, while others were revised versions of old favorites. In the latter category were the Jenkins-Keogh bills (again bearing the numbers H. R. 9 and H. R. 10) which would provide tax deferment on money paid in annuity plans, and the Bricker Amendment for keeping international treaties from affecting internal laws of the U. S.

The tax deferment proposal was changed in several respects, the most important being a provision for withdrawal of money from plans in advance of age 65, upon payment of a tax penalty. The key section in the proposed constitutional amendment sponsored by the Ohio Senator states that "a provision of a treaty or other international agreement not made in pursuance of this Constitution shall have no force or effect."

One of the few surprises in the opening day rush to the bill hoppers was a bill by Rep. Poage (D., Tex.) to authorize the Secretary of HEW to make long-term, 3%-interest loans to non-profit hospitals for construction and expansion of facilities, including nursing homes. Certain sectarian groups have been pressing for just such a plan in lieu of taking federal grant money under the Hill-Burton program.

New Appointees

Moving to fill two major spots in the Department of HEW, President Eisenhower has named as Assistant Secretary 36-year-old Elliott L. Richardson, one time law clerk to Judge Learned Hand and Justice Felix Frankfurter, assistant to Senator Saltonstall and consultant to former Gov. Christian Herter, now Under-Secretary of State.

Heart Page (cont'd.)

Ideally, he should make an electrocardiogram on every candidate for digitalization. He should alert the patient to be on the lookout for anorexia, nausea, headache, and visual symptoms and to report promptly any new symptoms of any kind. He should avoid excessive mercurial diuresis, the administra-

tion of steroids, purgation, and other measures which deplete the body of potassium, and he must be sure the patient has an adequate dietary intake (orange juice, meat, meat extracts) of this electrolyte. He should stop the drug at the first warning of toxicity, using it later, if indicated, in more conservative dosage.

Post Office Box 899

physician's bookshelf



Books Received

How to Make Health Visible, A Catalog of Effective Tools for Promoting Better Health, Cleveland Health Museum, 1955, 35 pp., \$1.00.

Reviews

Wolstenholme, G. E. W., and Cecelia M. O'Connor, **HISTAMINE** (Ciba Foundation Symposium), Little, Brown and Company, Boston, 1956, 472 pp., \$9.00.

When one considers that the anti-histaminic drugs are undoubtedly among the most useful and widely employed agents prescribed today for the relief of symptoms, it is surprising to this reviewer to find how little is yet known of the role in the body of the object of their antagonism, namely histamine.

This superbly edited symposium, itself a happy example of what a great pharmaceutical house and a learned body of researchers can do to help each other, demonstrates that our body of fundamental knowledge as to the origin, location, mechanism of release, and fate of histamine has grown tremendously; but unfortunately we cannot answer the fundamental question regarding histamine—namely, why is it present in the body and what does it do?

W. Feldberg, J. H. Gaddum, W. D. M. Paton, U. S. von Euler, and numerous other noted figures in the field of neurohumeral transmission and autonomic drugs contribute to this volume. Their results are often brilliant, but as yet there is no hypothesis into which all the data fits.

In summary, histamine has been shown to be widely distributed in every organ and body fluid (except, interestingly enough, in carcinoma). It is intimately related to heparin and is found almost exclusively in mast cells along with heparin. Many of the histamine-releasing chemicals are potent antagonists of heparin. There are now many types of histamine-releasing agents such as sensitizing compounds (i.e. antigen-antibody reactions), compounds damaging tissues (i.e. venoms) proteolytic enzymes, large molecules (Dextran), and dibasic and polybasic compounds. Much work is presented describing the mechanism of action of these agents. Especially important has been the use of histamine-releasing bases in conjunction with anti-histaminic compounds as experimental tools in evaluating the role of endogenous histamine. The results are often surprising. It now seems doubtful that the release of histamine is responsible for many things it was previously suspected of causing, such as the anaphylactic reaction, bronchial constriction in asthma, the vasodilation produced by adrenaline, the vascular reaction in reactive hyperemia, and post-exercise hyperemia. However, a new and as yet unidentified substance called "slow-reacting substance" has been demonstrated by several members of this symposium, and it seems to be the mediator of these important clinical phenomena.

The future seems promising, and if the roles of histamine and "slow reacting substance" are finally clarified it seems likely that we will understand and perhaps be able to treat more effectively a wide range of

human diseases including asthma, many skin diseases, peptic ulcer, and other conditions with disordered autonomic function.

Joseph A. Wilber, M.D.

Diggs, L. W., M.A., M.D.; Sturm, Dorothy, and Bell, Ann, B.A., **THE MORPHOLOGY OF HUMAN BLOOD CELLS**, W. B. Saunders Co., Philadelphia, 1956, 181 pp., \$12.00.

This atlas was written "primarily for medical students and student technologists who for the first time are learning about the morphology of normal and pathologic cells, for medical technologists who daily examine blood smears in physician's offices, clinics, and hospitals, and for physicians who supervise laboratories. Emphasis is placed on the characteristics of individual cells and on different morphology rather than on diseases of the blood and blood-forming organs." To this end this book admirably meets its purpose.

The first section is made up of color plates beautifully drawn by Dorothy Sturm and which were previously published by Abbott & Co. in their "What's New." The second section is text which also contains excellent diagrams and black and white photomicrographs and drawings. The terminology used is that recommended by "The Committee for the Clarification of Nomenclature of Cells and the Diseases of the Blood and Blood Forming Organs" sponsored by the American Society of Clinical Pathologists and the American Medical Association (1949-50). In addition to well done chapters on normal and pathologic blood cells, there are comprehensive chapters on fixed tissue cells, on the Lupus Erythematosus Cell, and one on techniques and methods.

With its special loose-leaf binding, the book spreads out flat for easy reference. For practical, every-day hematologic morphology it is highly recommended.

Milton H. Freedman, M.D.

Friedberg, Charles K., M.D., **DISEASES OF THE HEART**, W. B. Saunders Company, Philadelphia, 1956, 1161 pp., 157 figs., \$18.00.

This book fills a real need in the medical literature for a complete and up-to-date textbook on heart disease. Dr. Friedberg covers this field with remarkable thoroughness. Particular emphasis is placed on cardiac physiology and the newer laboratory techniques of diagnosis and research. The clinical aspects and treatment of congestive failure, the arrhythmias, and the various etiological types of heart disease are covered thoroughly, although physical diagnosis is perhaps emphasized less than in some textbooks. This book is surprisingly up-to-date in its coverage of the more recent work and in its references. Some of the fairly recent work discussed includes: left heart catheterization, spatial vectorcardiography, ballistocardiography, the use of inersine and ecolid in the treatment of hypertension, recent studies into the causes of atherosclerosis, problems related to mitral valve surgery, and the newer surgical techniques in congenital heart disease.

For the average medical student this book is too long and detailed for routine use, but it would be valuable as a reference work. For medical libraries, and for those engaged in internal medicine or general practice with an interest in cardiology, this book is in my opinion the most valuable one in its field.

J. Grant Wilmer, M.D.



abstracts by georgia authors

Boyd, Montague L., 563 Capitol Ave., S.W., Atlanta, Ga. "Suprapubic or Retropubic Prostatectomy?" *J. Urol.* 76:625-636 (Nov.) 1956.

Suprapubic prostatectomy is advocated as a simpler, safer, and perhaps a more effective operation than retropubic prostatectomy.

Simple enucleation, without injury to the prostatic capsule, incision of the prostate or of the capsule, or the placing of sutures in the capsule or prostate is possible only in suprapubic prostatectomy. There is no need to expose or enter the retropubic space, and an infection in the retropubic space or osteitis pubis has never been encountered by the author in any of the suprapubic prostatectomies or suprapubic cystotomies he has performed. Careful preoperative preparation, suitable operative technic, and close postoperative attention are, of course, necessary. Perhaps such care consumes more of the surgeon's time with suprapubic prostatectomy, but it seems to the author that the results justify the extra effort.

Lester, William M., R. A. Bartholomew, E. D. Colvin, W. H. Grimes, John S. Fish, and W. H. Galloway, 272 Boulevard, N.E., Atlanta, Ga. "The Role of Retained Placental Fragments in Immediate and Delayed Postpartum Hemorrhage." *Am. J. Obst. & Gynec.* 72:1207-1213 (Dec.) 1956.

Among 9732 patients, 40 of 85 instances of retained placental tissue resulted in abnormal puerperal blood loss. Most were suspected soon after delivery, on placental examination or because of hemorrhage, and were confirmed by uterine exploration. Retained fragments accounted for 4.5 per cent of cases of hemorrhage in the early puerperium (first 24 hours).

In 18 cases in which placental fragments remained in the uterus into the late puerperium, abnormal bleeding uniformly occurred. In 12 cases gross hemorrhage required hospitalization, usually between the fifth and fifteenth days after delivery. These accounted for 40 per cent of severe late puerperal hemorrhages. Treatment in cases of delayed hemorrhage consists of removing all placental tissue from the uterus and use of a uterine pack.

Cautious management of the third stage of labor, careful examination of the placenta, and liberal use of uterine exploration can reduce the incidence of such hemorrhages. Early curettage in all cases with gross late puerperal hemorrhage will reduce the risk and morbidity from retained placental fragments.

Bauer, Heinz; Morton Robbins; Rose Sachs; and Martin M. Cummings, Emory University Hospital, Emory University, Ga. "Tuberculous Pericarditis Among Veterans."

J. Chronic Diseases 4:559-578 (Dec.) 1956.

Tuberculous pericarditis among U.S. veterans discharged from the VA Hospital system between January 1950 and June 1952 was studied by abstracting the patients' folders and analyzing the findings statistically. Survivorship data were determined for a minimum of three and a maximum of five years after the onset of clinical manifestations of pericarditis. The annual incidence rate was estimated to be about 2.4 cases per million veterans. The incidence among non-white veterans was about 12 times as high as among white veterans. Cardiac enlargement, dyspnea and fever were the most common findings. Signs of congestive heart failure predominated among patients seen later than two weeks after clinical onset of pericarditis, while chest pain was present mainly in those observed within the first two weeks. Nine patients died, three of them entirely of their extrapericardial tuberculosis. The remaining six patients died with marked cardiac impairment. Of 41 patients with acute tuberculous pericarditis, 37 received Streptomycin and PAS. Twenty-nine of these patients had more than two months of chemotherapy. Death interrupted chemotherapy in three patients. The fatality rate in untreated tuberculous pericarditis is about 85 per cent so that the occurrence of only eight deaths among 37 treated patients seems encouraging. Eleven of the 41 patients with acute tuberculous pericarditis later developed constrictive pericarditis.

Bennett, Truett, 144 Ponce de Leon Ave., N.E., Atlanta, Ga. "Midfacial Fractures," *South. M. J.* 49:1252-1257 (Nov.) 1957.

The cardinal signs of facial fracture are malocclusion, diplopia, trismus, and deformity of facial contours. Early recognition and treatment are desirable in that union of facial bones is rapid and after ten days, open reductions may become necessary. Depression of the zygomatic arch is best elevated by the temporal approach. Comminuted fractures of the zygoma are treated by a transantral reduction. Complete fractures of the maxilla are treated by first establishing dental occlusion by means of arch bar splints and then immobilizing the fragments by tractions from a head cast to the splints. Internal wire supports or direct wiring of fragments are sometimes used.

Warkentin, John, 1293 Peachtree Street, N.E., Atlanta, Ga. "Support Through Non-Reassurance." *Am. J. Psychotherapy* 10:709-715 (Oct.) 1956.

The utilization of non-reassuring or aggressive behavior by the psychotherapist, as described by the author, is contrary to the popular belief that the establishment of a useful transference

relationship early in psychotherapy with neurotics requires accepting and non-threatening attitudes by the therapist. This general rule ignores the individual differences among patients. There are some patients who remain superficial and non-involved as long as the therapist technically remains accepting, permissive and reassuring. The guilt and shame of other patients is so intense that their anxiety is increased by a therapist who appears entirely positive, and they may consider him untrustworthy or even dishonest. This makes the development of transference almost impossible. With such neurotic patients, the failure to reassure, and at times the overt expression of negative attitudes by the therapist, may be advantageous to the development of a positive transference. Case fragments are presented illustrating the use of negative expressions ranging from a simple withholding of reassurance, to the making of directly hostile statements.

It was found to be of primary importance that the expression of feeling by the therapist be an honest representation of his emotional experience at the time. Whenever such aggression was utilized simply as a technique, it was almost immediately detected by the patient to the detriment of the therapy. When appropriately utilized, the therapist's expressions of aggression were found to clarify the therapeutic relationship for the patient, increase his motivation, and offer the patient a key figure against whom he may aggress in the interview. This kind of effort by the therapist must originate in his conviction that the patient is not feeble or helpless in a direct and honest interpersonal relationship; that the patient has essentially the same power potentially available to him as that which is present in the therapist, and that the patient has the capacity to mobilize such power in the interaction with the therapist. Even though the therapist may express directly hostile attitudes, if this behavior arises from his wholehearted commitment to the effort of helping the patient, it will be experienced by the patient not as hate, but as love.

Negative attitudes by the therapist can easily be destructive to the development of a working relationship. Criteria for the use of non-reassurance in therapy should include the following: That the patient be neurotic, not prepsychotic; that the therapist be sufficiently experienced; that he genuinely accepts the patient; that transference has failed to emerge in response to a positive, reassuring approach by the therapist. Also, the therapist should be certain that his negative response to the patient is appropriate.

Postgraduate Courses — see pages 84A and 86A
on ELECTROLYTES — Emory University School of Medicine
on CIRCULATORY DISORDERS — Medical College of Georgia

THE ASSOCIATION

Council of the MAG

December 15, 1956

CHAIRMAN J. W. CHAMBERS, LaGrange, called the meeting of the Council of the Medical Association of Georgia to order at 2:20 p.m.

Officers and councilors present included: Hal M. Davison, Atlanta, President; H. Dawson Allen, Jr., Milledgeville, Immediate Past President; Carl C. Aven, Marietta, 1st Vice-president; Bernard P. Wolff, Atlanta, 2nd Vice-president; Thomas W. Goodwin, Augusta, House of Delegates Speaker; Lee Howard, Sr., Savannah, 1st District Councilor; George R. Dillinger, Thomasville, 2nd District Councilor; W. G. Elliott, Cuthbert, 3rd District Councilor; J. W. Chambers, LaGrange, 4th District Councilor and Chairman of Council; J. G. McDaniel, Atlanta, 5th District Councilor; Henry H. Tift, Macon, 6th District Councilor; Ralph W. Fowler, Marietta, 7th District Vice-councilor acting as councilor in the absence of D. Lloyd Wood, Dalton, 7th District Councilor; F. G. Eldridge, Valdosta, 8th District Councilor; Charles R. Andrews, Canton, 9th District Councilor; and J. Victor Roule, Augusta, 10th District Vice-councilor acting as councilor in the absence of H. L. Cheves, Union Point.

Vice-councilors present included: Charles S. Jones, Atlanta, 5th District; and James Hicks, Brunswick, 8th District.

Also in attendance were Chris J. McLoughlin, Chairman, MAG Public Service Committee; Edgar Woody, Jr., Atlanta, JMAG Editor; Walter E. Brown, Savannah, 1957 Annual Session Liaison Chairman; and Messrs. Milton D. Krueger and John F. Kiser of the Headquarters Office staff.

Chairman Chambers called on Mr. Krueger to read the minutes of the Council meeting, September 15-16, 1956, and these minutes were approved with the following correction brought to the attention of Council by Luther H. Wolff in a letter of November 29, 1956, as follows: "I would like the records to show that the facilities of the Columbus Blue Shield Plan were offered to the Medical Association of Georgia in the capacity of Fiscal Agent for the Association in connection with "Medicare," Public law 569, and that through an agreement with the other Blue Shield Plans in Georgia, that the facilities of any and all of the Blue Shield Plans in Georgia were offered as fiscal agent to the Association." Mr. Krueger read the Executive Committee of Council minutes of September 16, 1956; the called meeting of Council minutes of October 28, 1956; the Executive Committee of Council meeting minutes of October 2 and the Executive Committee of Council meeting minutes of November 28, and these minutes were approved as read.

Hospital Care Study Commission Report—Mr. John F. Kiser, Assistant Executive Secretary, reported for Milford B. Hatcher, Chairman of the MAG Hospital Committee. Mr. Kiser reviewed the past history and progress of the commission's activities and explained in detail a rough draft of proposed legislation in the State of Georgia as a result of the Hospital Care Study Commission's activity.

Industrial Health Council of Greater Atlanta, Inc.—Chairman Chambers called on Mr. Krueger to present the recommendation of the MAG Industrial Health Committee on the request for Association approval of the Industrial Health Council of Greater Atlanta, Inc. In behalf of Duncan Shepard, Industrial Health Committee Chairman, Mr. Krueger read the following letter of December 5, 1956, in which this recommendation was received for the action of Council as follows: "The Industrial Health Committee of the Medical Association of Georgia met in Atlanta on November 18, 1956, to consider the request of the Industrial Health Council of Greater Atlanta, Inc., for approval by the Medical Association of Georgia. All literature on this organization and all the information about it was presented to the committee, and after a thorough discussion, the committee decided that although they saw no objection to the Industrial Health Council of Greater Atlanta, Inc., and their actively functioning throughout the State, that the committee was not aware of the local industrial-medical situation in each county and thought that the situation would vary from county to county. Therefore, the committee decided that it should not give blanket approval to the Industrial Health Council of Greater Atlanta, Inc., but thought that this organization should contact the county medical society in any county where they wish to operate for that society's approval. It was thought this way that the practicing physicians on the local level would be given the opportunity to approve or disapprove the operation of the council (Industrial Health Council of Greater Atlanta), and that the council would have better cooperation from the local physicians if this were done."

It was moved that the report submitted by Duncan Shepard in behalf of the MAG Industrial Health Committee be approved as the committee recommended.

Unemployment and Sales Tax Data—Mr. Krueger read a December 6, 1956, communication from the Association Attorney, Mr. John Dunaway, relative to the State of Georgia unemployment compensation tax. It was moved that the Association pay this tax as levied in the State of Georgia. Mr. Krueger then brought to the attention of the Council the Association Attorney's advice relative to sales tax. It was moved that this commitment as budgeted, be met.

JMAG Journal—Chairman Chambers called on the *Journal of the Medical Association of Georgia* Editor Edgar Woody, Jr., who gave a detailed report of the Southeastern State Medical Journal Conference sponsored by the Association, November 3-4, 1956. Dr. Woody also brought to the attention of the Council the submission of data by the deLeon Laboratories of Atlanta, Georgia, for permission to advertise in the state medical journal. Dr. Woody further stated that after due and thorough investigation as Editor of the *JMAG*, he would recommend that this firm be allowed to advertise in the *Journal*. It was moved that approval on a one year probationary period be given to the deLeon Laboratories, Inc., to advertise in the *Journal of the Medical Association of Georgia*.

Medicare, Public Law 569—Chairman Chambers called on Mr. Krueger to report on the November 12, Washington, D. C., negotiations with the Department of the Army on the Dependents' Medical Care Act, Public Law 569, 84th Congress. Dr. Chambers re-

ported on the maximum allowable fee schedule as negotiated, and Dr. Dillinger reported on the fiscal agent contractual negotiations. Mr. Krueger described the implementation of this act after said contract was signed by the Medical Association of Georgia and the Government, November 3, 1956. Mr. Krueger also informed the Council that Mr. Dougald M. Avera had been employed by the Association at the direction of the Executive Committee of Council to operate Medicare administration as far as the Association was concerned in its contractual relationship in implementing this act.

American Medical Education Foundation Report—Mr. John Kiser, reporting for Ben K. Looper, Chairman of the AMEF Committee, informed the members of Council about the November 30, 1956, all-member AMEF mailing, and discussed plans with the Council for 1957 activity of the AMEF Committee.

Council Finance Committee Report—George R. Dillinger, Chairman of the Council Finance Committee, reported on the proposed 1957 budget for the Medical Association of Georgia which had been forwarded to all voting members of Council on December 12, 1956. This budget, as submitted by Dr. Dillinger is noted herein in comparison with the 1956 budget and actual income and disbursements through December 6, 1956.

	1956 Budget	Income and Disbursements 12/6/56	1957 Tentative Budget
INCOME			
Income from Dues	\$55,500.00	\$57,925.00	\$57,000.00
Journal Advertising	23,000.00	25,325.69	25,000.00
Fees Exhibitors A. S.	9,000.00	10,650.00	8,750.00
Int. & AMA Service	2,000.00	2,156.87	2,200.00
	\$89,500.00	\$96,057.56	\$92,950.00
DISBURSEMENTS			
1. Salaries	\$26,600.00	\$26,650.00	\$26,675.00
2. <i>Fixed Allotments</i>			
Pension Payments	\$ 1,200.00	\$ 600.00	\$ 1,200.00
Honorarium—Pres.	1,000.00	1,000.00	1,000.00
Attorney Retainer	1,200.00	1,200.00	1,200.00
Annual Audit	400.00	500.00	500.00
Cont. F.C.M.S.	1,500.00	1,500.00	1,500.00
Ins. & Bonds Per.	100.00	20.40	1,000.00
Woman's Auxiliary	1,300.00	1,300.00	1,300.00
Better Health Council	1,200.00	1,200.00	1,200.00
	\$ 7,900.00	\$ 7,320.40	\$ 8,900.00
3. <i>Journal Publications</i>			
Salaries	\$ —	\$ —	\$ 4,800.00
Engraving & Cuts	800.00	826.01	900.00
Editorial Asst.	150.00	150.00	150.00
Stationery	650.00	644.77	300.00
Postage	500.00	495.00	500.00
Clipping Service	250.00	205.00	250.00
Add. & Supplies	200.00	178.86	200.00
Copyright	50.00	48.00	50.00
Printing	22,000.00	24,992.23	26,000.00
Sales Tax	—	—	780.00
Sundry	—	—	50.00
	\$24,600.00	\$27,555.87	\$33,980.00
4. <i>Headquarters Expense</i>			
Travel	\$ 5,000.00	\$ 6,263.22	\$ 4,000.00
Travel AMA Del. & Sec.	—	—	2,000.00
Meetings	500.00	496.80	500.00
Stat. Print. & Sup.	1,200.00	1,537.08	1,500.00
Postage	1,000.00	1,336.67	1,500.00
Tel. & Tel.	\$ 2,200.00	\$ 2,741.69	\$ 2,500.00
Depreciation	500.00	—	500.00
Office Sup. & Exp.	600.00	479.11	500.00
Dues & Sub.	200.00	196.01	200.00
Janitor Service	300.00	300.00	300.00
Payroll & Unemp. Tax	600.00	517.00	1,400.00

Sundry	600.00	409.19	500.00
	\$12,700.00	\$14,276.77	\$15,400.00
		\$ 267.09	(1957)
5. Annual Session	\$ 9,000.00	11,557.94	\$10,000.00
6. <i>Committee Expense</i>			
1. Rural Health	\$ 200.00	\$ 185.27	\$ 350.00
2. Medical Defense	200.00	1,483.02	500.00
3. Legislation	1,000.00	399.92	1,400.00
4. Maternal Welfare	200.00	—	200.00
5. Industrial Health	100.00	100.60	100.00
6. Public Relations	1,000.00	715.14	1,000.00
7. Ins. & Economics	300.00	400.97	300.00
8. Awards	150.00	122.32	100.00
9. AMEF	—	—	100.00
10. Veterans Affairs	150.00	—	150.00
11. Hosp. Relations	150.00	103.73	150.00
12. Hist. & Vital Stat.	300.00	—	—
13. Med. Civil Prep.	50.00	9.79	50.00
14. Blood Banks	50.00	—	50.00
15. Mental Health	250.00	12.00	275.00
16. Crawford W. Long	—	44.57	100.00
17. Medical Education	—	—	100.00
	\$ 4,200.00	\$ 3,576.73	\$ 4,925.00
Total Disbursements	\$85,000.00	\$91,204.80	\$99,880.00
Contingent Fund	4,500.00	4,941.90	*6,930.00
Georgia Plan	—	399.43	—
Employee's Hosp.	—	442.10	—
Liability Insurance	—	311.77	—
South. Journal Conf.	—	391.16	—
Equip. Diebold Files, Dictaphone	—	1,403.19	—
		\$ 2,947.65	
Balance Contingent Fund		\$ 1,905.11	
Bank Balance (December Salaries Deducted)		\$ 7,347.11	

It was moved that the proposed 1957 budget be approved and become the Association budget for the calendar year 1957. Discussion ensued by individual members concerning said deficit indicated in this 1957 budget. This motion was then approved.

It was moved that any balance accruing at the end of a calendar year from unexpended committee funds should revert to the general fund. Approved.

It was moved that the travel expenses as allocated for the AMA delegates and the secretary or executive secretary in attendance at the annual and interim meetings of the American Medical Association be separated as a single budget item, and so shown. Approved.

It was moved that the following employee policies be adopted this date as follows:

(1) That each Association employee be covered at the Association's expense by Blue Shield-Blue Cross Insurance (already in force per December 17, 1955, Executive Committee of Council meeting minutes).

(2) Sick Leave—That each employee be retained on the payroll for the following prescribed period in the event of actual sickness or accident and that any absence due to actual sickness or accident extending beyond the below limitation would be considered absence without pay at the discretion of the Executive Committee of Council.

1st year of employment—1 week
2nd year of employment—2 weeks
5th year of employment—3 weeks

(3) Vacations—That each employee be allowed the following annual vacation with pay:

* Deficit

1st year of employment—1 week

2nd year of employment—2 weeks

5th year of employment—3 weeks

(4) Christmas Bonus—That each employee receive an annual bonus at Christmastime, if that employee is on the Association payroll as of December 25, and at no time during the year should an employee receive additional bonus and the amount of this Christmas bonus to be set as follows:

1st year of employment—one-quarter month's pay

2nd year of employment—one-half month's pay

5th year of employment—three-quarter month's pay

10th year of employment—one month's pay

The motion further stated that since all employees had received certain bonuses at annual session time the amount of this bonus should be deducted from the above schedule and that the above schedule should become effective immediately. The policies contained in this motion were then approved as stated in items 1, 2, 3, and 4 above.

By general agreement it was approved that the Council Annual Session Committee Chairman and the Executive Secretary jointly submit a proposed budget for the Annual Session 30 days prior to said annual session to the Chairman of the Finance Committee.

By general agreement it was approved that a Polaroid Land Camera should be purchased for the *Journal of the Medical Association of Georgia*, and the amount of expenditure for this equipment should not exceed \$100.00. It was further noted that supplies for the operation of this camera would be chargeable to the *Journal* account.

It was moved that as of the 1956 Annual Session and effective after that date that the salary of the secretary of the Association be \$1,200.00 annually, and that the salary for the treasurer be \$500.00 annually. It was left to the discretion of the Council and the physicians elected and appointed to these positions as to whether this should be listed as salary or honorarium. This motion was made to coincide with those items as budgeted in the 1957 budget. Approved.

It was moved that \$3,000.00 be awarded Secretary-Treasurer Poer for the calendar year 1956 as honorarium in addition to the salary of the Secretary-Treasurer and that this honorarium practice be discontinued in the future unless subsequent Councils so choose because of unforeseeable circumstances. Approved.

It was moved that the Association Council commend the Finance Committee and Dr.'s Chambers and Poer for their work in compiling the budget and further that Council voice a vote of confidence and appreciation to these physicians for their splendid efforts in this connection. Approved.

1957 Annual Session Report—Chairman Chambers called on J. G. McDaniel, Council Annual Session Committee Chairman, and Walter E. Brown of the Annual Session Liaison Committee, to report on the 1957 MAG Annual Session. Dr. McDaniel reported that the General Practitioners reconvened meeting to be held Monday night, April 29, 1957, would be on the subject of "Social Security and the Physician." Dr. McDaniel also reported that the panel on "Accidents" scheduled for Wednesday morning May 1, 1957, had been arranged. Walter Brown reported that all

scientific section chairmen had been contacted and that the scientific program was nearly completed. Dr. Brown commended T. A. Peterson for doing an excellent job on local arrangements in Savannah.

Interprofessional Council — Chairman Chambers called on Chris J. McLoughlin Chairman of the Interprofessional Council of Georgia representing the Medical Association of Georgia in behalf of the MAG Public Service Committee, who reported that a meeting of the Interprofessional Council of Georgia was held Sunday, December 2, 1956, in the Biltmore Hotel, Atlanta. Dr. McLoughlin was requested by the members of the Interprofessional Council to forward to the MAG Council a resolution for consideration requesting approval for the Interprofessional Council to seek clarification and enforcement of certain portions of the State Pharmacy Law. Dr. McLoughlin further reported on the past history of the Interprofessional Council and its present activity. It was moved that the Medical Association of Georgia request the Interprofessional Council to seek clarification and enforcement of certain portions of the State Pharmacy Law per the Interprofessional Council December 11, 1956, letter addressed to Dr. Hal Davison, President of the Medical Association of Georgia.

Public Service Committee Report—Chris McLoughlin, Chairman of the MAG Public Service Committee, reported on the progress of the membership indoctrination booklet and the Association safety program and in that connection showed the MAG member safety stickers which will be distributed within the next month.

Chairman Chambers recessed the meeting.

December 16, 1956

CHAIRMAN CHAMBERS CALLED the reconvened meeting of Council to order at 8:30 a.m., December 16, 1956.

In addition to the members present December 15, the following members of Council were present: David Henry Poer, Secretary-Treasurer; Eustace A. Allen, Atlanta, AMA Delegate; Clarence B. Palmer, Covington, Vice-councilor; and H. L. Cheves, Union Point, Councilor. In addition, were Albert Deal, Statesboro, member of the Legislative Committee; David R. Thomas, Jr., Augusta, Chairman, Insurance and Economics Committee.

Chairman Chambers called on Carl C. Aven, 1st Vice-president, for the invocation.

Newton County Medical Society Resolution—Chairman Chambers called on Clarence B. Palmer, member of Newton County and Vice-councilor, to read a resolution from the Newton County Medical Society concerning clarification and enforcement of certain pharmacy laws which was presented direct to the Georgia State Board of Pharmacy. Dr. Palmer also read an excerpt from the minutes of the Georgia State Board of Pharmacy business meeting of November 14, 1956, in which the Pharmacy Board requested that the Medical Association of Georgia issue a request to the Georgia Pharmaceutical Association at their annual meeting on this matter. It was moved this request be approved.

Legislative Committee Report—Chairman Chambers called on Eustace A. Allen, Vice-chairman of the Legislative Committee, and Mr. Kiser for a report on the

committee's activity. Mr. Kiser outlined salient points of the proposed Medical Practice Act Amendments; the proposed Hospital Care Study Commission program, and the Workmen's Compensation Act covering pre-existing diseases and the hiring of the handicapped. Dr. Allen reported on a reorganization of the AMA Legislative Committee and made recommendations on the reorganization of the MAG Legislative Committee. Dr. Deal reported on the revocation and injunction part of the proposed Medical Practice Act amendments and recommended certain changes concerning the foreign graduate problem relating to institutional licenses for foreign graduates. Chairman Chambers observed that this had been approved at the September 15-16, 1956, Council meeting and that the Headquarters Office would cooperate in every way possible with Dr. Deal in facilitating said recommendations.

AMA Seattle, November 27-30, 1956 Meeting Report—Eustace A. Allen, MAG-AMA Delegate, reported on the action of the November 27-30, 1956, Seattle, AMA Interim Session, especially emphasizing among other things the proposed revision of the AMA Code of Ethics. Dr. Allen reported that no action was taken on this revision at the Interim Session, and it was referred to the AMA House of Delegates for the June 1957 annual meeting.

Secretary-Treasurer Report — Chairman Chambers called on David Henry Poer, Secretary-Treasurer, and Dr. Poer expressed his appreciation to the 1956-57 Council for their support and cooperation. He further outlined the future position of the secretary-treasurer as perhaps having a separate treasurer, and that the elected M. D. secretary would further transfer administrative problems to the executive secretary and policy problems to the Council and the Executive Committee of Council. He further stated that the executive secretary's efficiency would depend on a high degree of activity of the Council, its executive committee and Association committee chairmen.

Insurance and Economics Committee Report—David R. Thomas, Jr., Chairman of the Insurance and Economics Committee, reported on the activity of his committee. He presented to Council a motion made by his committee: "On motion (Pinson-Floyd) it was moved that the Insurance and Economics Committee recommend to the MAG Council that the membership of the Medical Association of Georgia be included under the present Federal Social Security program OASI Title II. After ensuing discussion, this motion was unanimously approved with the request that it be written into the minutes that approval was given reluctantly and the principles involved in the present social security program." Dr. Thomas then called on Charles S. Jones, Insurance Board Co-chairman, who reported that an editorial on Social Security would appear in the January 1957 *Journal of the Medical Association of Georgia*, and he further discussed the pro and con of the physician and Social Security. On motion this Insurance Board motion concerning Social Security was referred to the MAG House of Delegates for action.

Richmond County Medical Society—Talmadge Memorial Hospital—Chairman Chambers expressed his appreciation to the members of Richmond County Medical Society in attendance at this meeting, and then remarked that the Council was meeting in Augusta this

date to aid them in solving certain problems connected with the Medical College of Georgia and the operation of the Eugene Talmadge Memorial Hospital. Chairman Chambers further stated that the Council was cognizant of those problems over the past years and that the chair would recognize anyone wishing the floor.

The December 11, 1956 Richmond County Medical Society resolution signed by Dr. J. L. Mulherin and others, was presented to the Council with the notation that this resolution was approved by the Richmond County Medical Society on December 11, 1956 by a vote of 30 to 29 in favor of the resolution, and that Richmond County Medical Society adopted this resolution subject to the approval of the Council of the Medical Association of Georgia. The resolution is as follows:

"In that a joint Committee of the Richmond County Medical Society composed of Drs. Joseph Mulherin, Chairman; Alfred Battey, John Martin, and Alex Murphy as representatives of that Body, and Drs. Edgar Pund and Rufus Payne as representatives of the Medical College of Georgia and the Talmadge Memorial Hospital, respectively, did meet on the night of December 7, 1956, and

"In that resolutions concerning the operations of the Talmadge Memorial Hospital and the Faculty of the Medical College of Georgia functioning as its Professional Staff were discussed, and

"In that these resolutions were unanimously approved by said Committee.

"These resolutions are respectively submitted for the approval of the Richmond County Medical Society and the Board of Regents of the State of Georgia.

"FEES:

Fees for services rendered by members of the Faculty of the Medical College of Georgia to patients who are able to pay shall be equivalent to those rendered for equivalent service by similar specialists in private practice in this area.

Fees shall be collected by the Hospital in the name of the physician rendering such service.

Fees shall be paid directly by the patient to the Research Fund of the Medical College of Georgia.

Use of the funds so obtained shall be for medical research purposes as approved by the Board of Regents upon the recommendation of a faculty committee established for this purpose.

This system of collection and use of such fees is within the limitation of the Code of Ethics of the American Medical Association.

"PUBLIC RELATIONS:

All public relations by the Talmadge Memorial Hospital and the Medical College of Georgia shall be handled by the Medical College of Georgia. Due cooperation will be maintained between this institution and the Public Relations Committee of the Richmond County Medical Society in regard to these matters.

"LIAISON COMMITTEE:

A Liaison Committee shall be appointed to consist of members from the Richmond County Medical Society. This Committee shall be empowered to meet at appropriate intervals with the President and/or Dean of the Medical College of Georgia and/or the Administrator of the Talmadge Memorial Hospital to investigate and act on minor problems which arise between private practitioners, patients, and these institutions.

"ADMISSIONS:

It is not and shall not become the policy of the Medical College of Georgia and the Talmadge Hospital to enter into the competitive practice of medicine. Insofar as patient care is concerned it is the purpose of these institutions, first and foremost, to care for the medically indigent of this State. It is realized, however, that dire emergencies and unusual circumstances will arise in which patients who are not so indigent will require the services of these institutions. Patients in such circumstances shall not be denied these facilities.

Those whose problems can be properly cared for through usual private channels shall be discouraged.

Admission of patients of unusual teaching interest shall be favored.

No patient may be accepted by either institution except by proper referral of his regular attending physician.

"CLINICAL FACULTY:

It is the desire of the Medical College of Georgia and the Richmond County Medical Society to develop a strong and excellently qualified Clinical Faculty. Every rightful effort shall be made to develop an atmosphere in this area which will entice and keep men of such desirable qualifications.

"PURPOSE:

This agreement is made in the sincere desire to maintain and develop the highest possible quality of Medical Care for the people of this area in the face of changing conditions of medical practice.

Signed,

J. L. Mulherin, M.D.	Edgar R. Pund, M.D.
John M. Martin, M.D.	Rufus Payne, M.D.
Alfred Battey, M.D.	Alex T. Murphey, M.D."

Open discussion of the resolution then ensued with Dr.'s Stephen Brown, George Wright, Charles Hock, Thomas Goodwin, J. L. Chandler, N. M. DeVaughn, Bruce Brown, R. C. McGahee, Jack Waters, Stuart Prather, Charles Friedman, Harry D. Pinson, William E. Bellamy, J. Robert Rinker, J. L. Mulherin, W. K. Philpot, C. M. Templeton, Ralph Chaney, George W. Wright, John M. Martin, Alfred Battey, Hoke Wommock, all of Augusta, Albert Deal, Statesboro, and many others in attendance.

Hal Davison asked Dr. Pund, President of the Medical College of Georgia, to explain the differences between the aforementioned December 11, 1956, Richmond County Medical Society Resolution, and the present plan of operation. Dr. Pund stated that there were no differences between this resolution and the present operational plan, but that this resolution clarified administrative policy under the present operational plan. Dr. Alex T. Murphey, author of the

Resolution, said that certain differences in this plan and the present operational plan were restrictive differences. Further discussion ensued with most of the attendees participating. After some 2½ hours of discussion, Chairman Chambers then excused the guests of the Council and recalled the Council meeting to order. After Council discussion of this December 11, 1956, Richmond County Resolution, it was moved (Goodwin-Poer) that Richmond County Medical Society be requested to obtain a more representative vote of the December 11, 1956, Richmond County Medical Society resolution in a called meeting of the Society with expediency in providing the MAG Council with such information, so that Council may in turn expedite its action on this Richmond County Medical Society resolution. This motion was then approved.

By general agreement, it was recognized that the Council would have to hold a called meeting at a date set by the Executive Committee in the near future after obtaining a more representative vote on the Richmond County Medical Society December 11, 1956, Resolution, from the Richmond County Medical Society, and after obtaining legal advice pertinent to the Richmond County Medical Society resolution. It was further agreed that Macon, Georgia, should be the selected site for this special called meeting on the Richmond County Medical Society problem.

By general agreement, it was approved that the Council of the Medical Association of Georgia hold its next regular meeting scheduled for March, 1957, at Radium Springs as the guests of the Dougherty County Medical Society, and that the Executive Secretary be instructed to so notify the officers of the Dougherty County Medical Society that their invitation had been appreciatively accepted.

On motion (Elliott-Poer) it was moved that a \$10,000.00 Association Government Bond which had passed its maturity date be put into a savings and loan association fund so that it might draw interest at the appropriate rate. This motion was then approved.

On motion (Poer-Tift) it was voted that the Council of the Medical Association of Georgia approve and provide the appropriate invitation for a regional AMA medico-legal conference tentatively scheduled for Atlanta in March. The Executive Secretary was so instructed to notify Mr. Joseph Stetler, Director of the AMA Law Department, to that effect. This motion was then approved.

By general accord and on motion duly made and seconded, a rising vote of thanks was given Thomas W. Goodwin and Victor Roule for their warm hospitality to the Council of the Medical Association of Georgia on the occasion of this meeting.

The meeting was adjourned at 2:15 p.m.

Mrs. Schaefer Appointed to Board of Education

GEORGIA'S GOVERNOR Marvin Griffin has appointed Mrs. W. Bruce Schaefer of Toccoa to represent the Ninth District on the State Board of Education. Mrs. Schaefer is the wife of the president-elect of the Medical Association of Georgia. She is a member of the state Democratic Executive Committee and president

of the Georgia Better Health Council. Mrs. Schaefer is also active in the National Society for Crippled Children; the Presbyterian Church; the Woman's Auxiliary to the MAG, of which she is a past president; Brenau Alumnae Association; the UDC; the DAR; and literary and garden clubs.

ANNOUNCEMENTS

Meeting Calendar

American Medical Association—June 3-7, 1957, The Coliseum, New York City.

American College of Physicians—April 8-12, 1957, Boston, Mass.

American College of Surgeons Regional Meeting—February 4-7, 1957, Roosevelt Hotel, New Orleans, La.

Medical Association of Georgia—April 28-May 1, 1957, DeSoto Hotel, Savannah.

Georgia Society of Anesthesiologists—April 21-24, 1957, Savannah.

Georgia Diabetes Association—April 28-May 1, 1957, DeSoto Hotel, Savannah.

Georgia Society of Ophthalmology and Otolaryngology—May 18-23, 1957, aboard S. S. Silverstar from Charleston, S. C.

Georgia Psychiatric Association—February 18, 1957, Atlanta.

Georgia Urological Association—April 28-May 1, 1957, DeSoto Hotel, Savannah.

Georgia Industrial Surgeons Association—April 28-May 1, 1957, DeSoto Hotel, Savannah.

Atlanta Graduate Assembly—February 18-20, 1957, Atlanta.

American College of Physicians 1957 Annual Session—April 8-12, 1957, Boston. For information write to Dr. Richard P. Stetson, 203 Commonwealth Ave., Boston 16, Mass.

American Congress of Physical Medicine and Rehabilitation—35th annual scientific and clinical session, September 8-13, 1957, Hotel Statler, Los Angeles, Calif. For information, write to the Executive Secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Ave., Chicago 2, Ill.

Annual Prize Lecture, American Congress of Physical Medicine and Rehabilitation—Manuscripts must be submitted by June 1, 1957. Contest open to medical students, interns, residents, graduate students in the pre-clinical sciences, and graduate students in physical medicine and rehabilitation. For information write to the American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Ave., Chicago 2, Ill.

1957 Mississippi Valley Medical Society Essay Contest—Any subject

of general medical or surgical interest including medical economics and education may be submitted by physicians who are members of the A.M.A. and are residents and citizens of the U. S. Cash prize—\$100; gold medal and certificate given. Essays must be submitted by May 1, 1957. Further details may be secured from Harold Swanberg, M.D., Secretary MVMS, 209-224 W. C. U. Building, Quincy, Ill.

American College of Surgeons Sectional Meeting—February 4-7, 1957, Hotels Roosevelt and Jung, New Orleans, La. Program will include panel discussions, symposia, scientific papers, cine clinic films on general surgery, and separate programs in the specialties of urology, ophthalmology, ob-gyn, otolaryngology, thoracic surgery, and orthopedic surgery. There will also be a joint nurses' program. For more information, write to the American College of Surgeons, 40 East Erie St., Chicago 11, Ill.

Fourth Interim Congress of the Pan American Association of Ophthalmology—April 7-10, 1957, Hotel Statler, New York, N. Y. The National Society for the Prevention of Blindness will meet at the same time. All ophthalmologists in good standing are invited to the Congress. Hotel reservations should be made direct with the Hotel Statler, New York.

First Pan American Cancer Cytology Congress—April 25-29, Miami Beach, Fla. Twenty-one nations of the Western Hemisphere are invited to attend the congress which is sponsored by the Southern Society of Cancer Cytology, the Cancer Institute at Miami, the Univ. of Miami, and the Cancer Cytology Foundation of America, Inc., New York. Physicians wishing to present scientific papers at the Congress should apply to Program Chairman, Dr. Wayne Rogers, P. O. Box 633, Coral Gables, Fla. Inquiries relative to scientific exhibits or motion picture presentations should be sent to Dr. Homer L. Pearson, P. O. Box 633, Coral Gables, Fla. Two awards of \$1,000 each will be presented to the two scientists presenting papers whose work is judged to represent "outstanding research in cancer cytology."

Atlanta Graduate Medical Assembly—February 18-20, 1957, Atlanta

Biltmore Hotel, Atlanta, sponsored by the Fulton County Medical Society. Visiting speakers include the following: Eugene Stead, M.D.; Sol Katz, M.D.; Joseph H. Burchenal, M.D.; W. D. Snively, M.D.; Edward P. Cawley, M.D.; C. Stewart Nash, M.D.; Arthur P. Stout, M.D.; Donald A. Covalt, M.D.; Mark Coventry, M.D.; Howard Mahorner, M.D.; John W. Hope, M.D.; James Hughes, M.D.; Herbert E. Schmitz, M.D.; William F. Mengert, M.D.; and Robert A. Hingson, M.D. The meeting is approved by the American Academy of General Practice for 18 hours credit, Category I. For further information concerning the program write: Atlanta Graduate Medical Assembly, 15 Peachtree Place N. W., Atlanta 9, Ga.

Cardiac Surgical Program—National Jewish Hospital at Denver, a free, non-sectarian institution, is expanding its facilities for cardiovascular patients with lesions amenable to surgical intervention. Only patients unable to pay for private care are eligible for admission. Since the hospital has a complete cardiopulmonary physiology laboratory, definitive diagnosis by the referring physician is not necessary. Inquiries concerning admission should be directed to Miss Grace Grossman, Director of Social Service and Rehabilitation, National Jewish Hospital, 3800 East Colfax Ave., Denver 6, Colo.

Symposium on Fats in Human Nutrition—March 15, 1957, Louisiana State University Auditorium, New Orleans. Under the sponsorship of the A. M. A. Council on Foods and Nutrition. Special emphasis will be on fats, cholesterol, and atherosclerosis; the meeting is specially planned for general practitioners. Speakers will include the following: L. Emmet Holt, Jr., M.D., director of the department of pediatrics, N. Y. U. School of Medicine; Donald S. Fredrickson, clinical associate, National Heart Institute, Bethesda, Md.; W. Stanley Hartroft, chairman of the department of pathology, Washington Univ., St. Louis, Mo.; Ancel B. Keys, Ph.D., director of the laboratory of physical hygiene, Univ. of Minn.; Edward H. Aherns, Jr., M.D., associate physician at the Rockefeller Institute Hospital, New York; Frederick J. Stare, head of the department of nutrition, Harvard

(Announcements)

School of Public Health. The American Academy of General Practice offers six hours of category I credit for attending the symposium. For further information write the Council on Foods and Nutrition, American Medical Association, 535 North Dearborn St., Chicago 10, Ill.

10th Annual Congress, International College of Surgeons—February 24-28, 1957, University of Mexico, Mexico City. For reservations and further information write to the International Travel Service, Inc., Palmer House, Chicago 3, Ill.

Hunters' Fall Meeting, South Dakota Medical Program and Pheasant Hunting—October 1-5, 1957, Mitchell, South Dakota. Program will feature morning scientific sessions, afternoon hunting and evening scientific and social sessions. Registration fee of \$100 covers out-of-state hunter's license, hunting guides, social events, and scientific program. Motel and hotel space has been reserved but registration is limited to the available housing. Wives who hunt pay full registration fee; those not hunting, \$75.00. For further details and reservations write to Mr. John C. Foster, Executive Secretary, South Dakota Medical Association, 300 First National Bank Bldg., Sioux Falls, S. D.

26th Venereal Disease Postgraduate Conference—College of Medicine, Memphis, Tenn., April 18-20, 1957, sponsored by the University of Tennessee College of Medicine and the Public Health Service. Course is designed to acquaint the practitioner with the latest developments in diagnosis, treatment, and management of the venereal diseases. No tuition will be charged. Applications for admission are to be sent to Dr. Henry Packer, Dept. of Preventive Medicine, Univ. of Tenn. College of Medicine, Memphis 3, Tenn.

2nd Inter-American Medical Convention—Hotel El Panama, Panama City, Republic of Panama, April 3-5, 1957. The meeting is sponsored by the Medical Society of the Isthmian Canal Zone. For information write to Dr. William T. Bailey, Dept. of Medicine, Gorgas Hospital, Ancon, Panama Canal Zone.

Ninth Annual American Academy of General Practice Scientific Assembly—March 25-28, 1957, Kiel Audi-

torium, St. Louis, Missouri. Among the speakers will be I. S. Ravdin, professor of surgery at the University of Pennsylvania; Philip Thorek, associate professor of surgery at the University of Illinois and professor of surgery at Cook County Graduate School. All sessions of the Congress of Delegates and many social functions will be held at the Sheraton-Jefferson Hotel. For information write to the American Academy of General Practice, Volker Boulevard at Brookside, Kansas City, Mo.

Clinical Workshop in Treating Circulatory Disorders—March 28-30, 1957, Medical College of Georgia, Augusta, Ga. This intensive postgraduate session will emphasize the capacity of drugs and other therapeutic agents to modify diseases of the circulation. Registrants will work closely with patients selected to illustrate the therapeutic problems under consideration. Faculty participating in the course include both visiting and Medical College of Georgia physicians. C. Thorpe Ray, associate professor of medicine at Tulane University School of Medicine, will be featured as will Thomas Findley, A. C. Witham, Herbert Schaefer, and R. P. Ahlquist, all of the Medical College of Georgia. A fee of \$25.00 will be charged for the session; registration is limited to 20 physicians. Application, accompanied by a check made payable to the Medical College of Georgia, should be made as soon as possible to: Dr. Virgil P. Sydenstricker, Dean, Postgraduate Education, Medical College of Georgia, Augusta, Ga.

Meeting, Georgia Division, American Cancer Society—March 15, 1957, Academy of Medicine, 875 West Peachtree St., N.E., Atlanta, Ga. Participants will be William U. Gardner, New Haven—"The Role of Steroids as Carcinogens"; John R. Heller, Bethesda—"Hopeful Trends in the Epidemiology of Cancer"; Harry M. Nelson, Detroit—"Value of Routine Vaginal Smears and Proctoscopies in Cancer Detection"; Eugene P. Pendergrass, Philadelphia—"A Critical Evaluation of Newer Modalities of Radio-therapy"; Owen H. Wangenstein, Minneapolis—"Current Status of the Second Look Procedure in Cancer of the Gastrointestinal Tract"; David A. Wood, San Francisco—"Trends in Research Related to Cancer of the Lung"; and Howard Snyder—"Kansas' Tumor

Registry Program." All Georgia doctors are invited and urged to come to this meeting. For further information write to the Georgia Division of the American Cancer Society, Inc., 2025 Peachtree Road, N.E., Atlanta 9, Ga.

Two-Day Course in Electrolytes—March 29 and 30, 1957, Emory University School of Medicine, Emory University, Ga. Course will be under the direction of Arthur Merrill, associate professor of medicine, and other faculty members of Emory University. Visiting faculty includes Ted S. Danowski, professor of research medicine, University of Pittsburgh, and Louis G. Welt, professor of medicine, University of North Carolina. For further information, address Postgraduate Teaching Program, Emory University School of Medicine, Atlanta, Ga.

Thirtieth Annual Spring Congress in Ophthalmology, Otolaryngology, Rhinology, Laryngoscopy, Facio-maxillary Surgery, Bronchoscopy and Esophagoscopy—Gill Memorial Eye, Ear and Throat Hospital, April 1 to 6, 1957, Roanoke, Va. Visiting faculty will include Seymour Alpert, Washington, D. C.; George Baylin, Durham, N. C.; Edward A. Carr, Jr., Ann Arbor, Mich.; James H. Doggart, London, England; Harold F. Falls, Ann Arbor, Mich.; Frederick A. Figi, Rochester, Minn.; Samuel Fomon, New York; Dan M. Gordon, New York; Elmer Hess, Erie, Pa.; Maynard Hine, D.D.S., Indianapolis; Howard P. House, Los Angeles; Jay G. Linn, Jr., Pittsburgh; Frank W. Newell, Chicago; Hugh L. Ormsby, Toronto; Harry L. Rogers, Philadelphia; Albert D. Ruedemann, Detroit; Frank B. Walsh, Baltimore; and Barnes Woodhall, Durham, N. C. Matriculation fee: \$80.00; date of matriculation: beginning on March 31st at the Hotel Patrick Henry. If you are eligible to receive training under the G. I. Bill of Rights, the V. A. has authorized payment to the Gill Memorial Hospital for your training period during the Spring Congress. Registration is limited. For further information, address Dr. E. G. Gill, Box 1789, Roanoke, Va.

DEATHS

ROBERT STALLINGS BURFORD, Brunswick, died on January 2, 1957 at the age of 54. Cause of death was a self-inflicted bullet wound.

(Deaths)

The physician was born in Brunswick, the son of Mrs. R. E. L. Burford and the late Dr. Burford. He attended the local schools and graduated from Vanderbilt University. He received his M.D. degree from that institution in 1925. Dr. Burford interned at Syracuse, N. Y., and St. Mary's Hospital in New York City and had practiced in Brunswick since 1928.

He was president of the Glynn County Board of Health, a member of the First Methodist Church, a former president and honorary member of the Brunswick Kiwanis Club; he was also plant physician of the Brunswick Pulp and Paper Company.

Funeral services were held at the First Methodist Church with interment in the family plot in Palmetto Cemetery. Among the pallbearers were Bert H. Malone, C. B. Greer, M. E. Winchester, and other members of the Glynn County Medical Society.

Surviving Dr. Burford are his wife; a daughter, Mrs. L. M. McLeod, Albany; a son, 2nd Lt. Robert S. Burford, Jr., U. S. Army; and his mother.

WILLIAM BEERS DOVE, 84, Macon, died on December 12, 1956, in a hospital in Macon. He had been ill for several months.

A native of Cedar Springs, Michigan, Dr. Dove had lived in Macon since 1912. He was a graduate of the University of Indiana and a member of the Bibb County Medical Society and St. Joseph's Church.

Surviving Dr. Dove are his wife, the former Miss Jean Cayo of Macon; one brother, John McMillen of Ft. Wayne, Ind.; one sister, Miss Grace McMillen, Ft. Wayne, and a nephew, W. C. Joanis, M.D.

Funeral services were held at St. Joseph's Roman Catholic Church with burial in Rose Hill Cemetery.

JOHN LUCIUS GARRARD, 75, Rome, died on December 4, 1956, at his home in Rome.

Dr. Garrard was born in Wilkes County and was a graduate of the Medical College of Georgia, class of 1907; he had practiced medicine in Rome and Floyd County for 50 years.

During his career he was twice president of the Floyd County Medical Society, president of the Seventh District Society, and president of the Georgia Urological Society.

Dr. Garrard was a pioneer aviation enthusiast, being the owner of the old Rome Airport for several years. He was owner of Floyd County's first airplane.

Funeral services were held at the Rome Second Avenue Methodist Church with burial in Prospect Cemetery.

Surviving Dr. Garrard are his wife; four daughters, Mrs. Meriam Garrard Hare, Mrs. R. T. Mitchell, Rome; Mrs. C. S. Lineberry, Windsor, Conn., and Mrs. W. B. Buchanan, Shelbyville, Tenn.; two sons, John L. Garrard, Jr., and Robert L. Garrard, both of Rome.

JAMES SWAYNE JOLLEY, 72, Homer, died on December 7, 1956, in Gainesville. Dr. Jolley had retired from active practice four years ago due to ill health.

Born in Franklin County, Dr. Jolley had lived in the Bushville District of Banks County since he was three years old. He attended Young Harris and Piedmont Colleges and was graduated from Atlanta School of Medicine, Atlanta, in 1913. He practiced in Maysville for one year and had continued to practice in Homer since 1914.

Funeral services were held at the Homer Methodist Church; interment was in Alta Vista Cemetery in Gainesville.

Dr. Jolley is survived by his wife, the former Miss Winnifred Sharp; a daughter, Mrs. Dan Syfan of Gainesville; two brothers, Sam R. Jolley, Homer; and Wilton Jolley of Miami, Fla.; a sister, Mrs. J. B. G. Logan, Homer; and two grandsons, Danny and Treadwell Syfan of Gainesville.

GEORGE TRACY OLMSTEAD, Savannah, died in an Augusta hospital on November 29, 1956.

Dr. Olmstead was a native of Liberty County and had lived in Savannah for 45 years. He was a graduate of the Southern College of Pharmacy and Emory University School of Medicine and did graduate work at the University of Vienna and the Eye, Ear, Nose and Throat Hospital in New York City. He began the practice of medicine in Savannah in 1916.

Dr. Olmstead was a former superintendent of Warren Candler Hospital, a past president of the Georgia Medical Society and a life member of the Medical Association of Georgia. Dr. Olmstead was a member of the Phi Chi Medical fraternity, a

32nd degree Mason and a Shriner. He was a member of the Wesley Methodist Church and had served on the board of stewards of the church for more than 30 years.

Survivors include his wife, the former Miss Mary Lee Jamison; two sons, G. T. Olmstead, Jr., M.D., Augusta, and Edward J. Olmstead, Atlanta.

Funeral services were held at Wesley Methodist Church; burial was in Bonaventure Cemetery, Savannah. Among the honorary pallbearers were E. R. Cook, III, J. K. Quattlebaum, J. C. Metts, R. A. Dooley, T. A. Grant, George H. Faggart, Robert Jackson, H. Y. Righton, and W. O. Bedingfield.

OSCAR W. ROBERTS, SR., 72, Carrollton, died on December 19, 1956, in a local hospital. Funeral services were held at the First Methodist Church with burial in City Cemetery.

Dr. Roberts was born in Campbell County and graduated from old Douglasville Junior College. He graduated with honors from the Atlanta Medical School, now Emory University School of Medicine. He interned as Wesley Memorial Hospital and began his medical practice in 1906 in the Hulett Community of Carroll County. He served with the U. S. Department of Public Health during World War I and moved to Carrollton in 1918.

Dr. Roberts was a surgeon for the Central of Georgia Railway for 33 years and was president of the Carrollton Clinic when it was merged with Tanner Memorial Hospital. He also served as chief of staff of Tanner Memorial Hospital.

Survivors include his wife, the former Miss Ola Byers; two sons, O. W. Roberts, Jr., and Cecil Roberts, both of Carrollton; a daughter, Miss Sarah Roberts, Carrollton, two sisters and a brother.

SOCIETIES

BIBB COUNTY MEDICAL SOCIETY met on January 7, 1957, in the library of the State Health Laboratory Building, Macon. Committee appointments for the year were announced, and the adoption of the new constitution and by-laws was voted upon. Principal speaker of the evening was Mr. Eugene Cornelius, head of the Macon Social Security Office, who spoke on "Social Security As It Pertains to Doctors." Offi-

(Societies)

cers elected at the December 4th meeting of the society are as follows: Henry H. Tift, president-elect; W. Derrell Hazlehurst, vice-president; and E. C. McMillan, secretary. Frank Houser succeeded Lon King, Sr., as president.

The BLUE RIDGE MEDICAL SOCIETY met in Blue Ridge on December 20, 1956, and elected Robert A. Burns, Blue Ridge, president; H. P. Hyde, McCaysville, vice-president; and Thomas J. Hicks, McCaysville, secretary.

CARROLL-DOUGLAS-HARALSON MEDICAL SOCIETY has elected new officers for 1957. They are as follows: C. V. Vansant, Jr., Douglasville, president; J. I. Vansant, Villa Rica, vice-president; T. E. Reeve, Carrollton, president-elect; D. S. Reese, Carrollton, secretary-treasurer.

On December 21, 1956, Harold P. McDonald, Atlanta, was elected president-elect of the FULTON COUNTY MEDICAL SOCIETY. Dr. McDonald will serve in 1958, succeeding Don F. Cathcart who went into office on January 3, 1957. Other officers include the following: J. Frank Walker, vice-president, and Thomas J. Anderson, Jr., secretary-treasurer. At the meeting held on December 21, McClaren Johnson, retiring president, presented certificates of appreciation to Mrs. J. K. Fancher, president of the society's auxiliary; Miss Edwina Davis, *Atlanta Journal* science and medical reporter, and Miss Katherine Barnwell, *Atlanta Constitution* reporter. The Fulton County Medical Society held its 52nd Anniversary Banquet on January 3, 1957, at the Piedmont Driving Club in Atlanta. The new officers were installed at this time. Guest speaker for the occasion was Mr. E. Smythe Gambrell, former president of the American Bar Association. His topic was "Freedom, Free Enterprise and the Professions." Past Presidents' Certificates were presented by Jack C. Norris, 25-Year Certificates by Major Fowler. Carl C. Aven presented the Aven Citizenship Cup to R. A. Bartholomew for his outstanding public service in the field of civil defense. General chairman for the banquet was Hugh Hailey.

New officers of the GEORGIA MEDICAL SOCIETY are as follows: Robert Lee Oliver, Savannah,

president-elect; John Zirkle, vice-president; W. W. Osborne, secretary; and Ralph O. Bowden, treasurer. The incoming president of the society is Walter E. Brown, succeeding Ruskin King. The Georgia Medical Society voted to send a \$300 contribution to the Hungarian Relief Fund for the express purpose of buying medical supplies.

Clyde A. Wilson has been elected president of the GLYNN COUNTY MEDICAL SOCIETY for the year 1957. Other new officers elected include E. R. Jennings, vice-president; and Eugene C. Kane, secretary-treasurer. All the officers are from Brunswick.

SPALDING COUNTY MEDICAL SOCIETY has elected J. R. Thomas, Griffin, president for 1957. Dr. Thomas is director of the Spalding Health Center and health centers in Lamar and Pike Counties. George T. Henry, Barnesville, was elected vice-president and James M. Skinner, Griffin, was elected secretary-treasurer of the society.

WALKER - CATOOSA - DADE MEDICAL SOCIETY officers for the year are as follows: Thomas A. Adkins, Rossville, president; Louis A. Williams, LaFayette, president-elect; and E. M. Townsend, Ringgold, secretary-treasurer. The board of censors will be composed of George C. Vassey, Rossville; Roy Pope, Jr., Chickamauga; and John P. Hoover, Rossville.

WARE COUNTY MEDICAL SOCIETY has elected W. B. Bates, Jr., Waycross, president of the society. Walter E. Lee, Jr., was elected vice-president, and Arthur M. Knight was re-elected secretary-treasurer. W. L. Flesch was elected to the Board of Censors to succeed Leo Smith. At the meeting, held in December, E. Adams Daneman, Waycross and St. Simons, was the principal speaker. His topic was "Personality Changes Due to Cerebral Arteriosclerosis."

R. E. Miller, Jesup, is the new president of the WAYNE COUNTY MEDICAL SOCIETY. Elected to serve with Dr. Miller were Fred M. Harper, Jesup, vice-president, and Daniel H. G. Glover, Jesup, secretary-treasurer. At the society's December meeting, at which the officers were elected, a discussion of chest lesions was led by J. Brooks Bowen, Jacksonville.

PERSONALS

First District

G. H. FAGGART, Savannah, fell from a ladder and fractured three neck vertebrae while working in his family lot in Bonaventure Cemetery. Dr. Faggart was clearing moss from the trees when he slipped and struck his head on the curbing of the lot.

L. M. FREEDMAN, Savannah, a past president of the Georgia Medical Society, has been elected president of the medical staff of Telfair Hospital. Other officers named were R. L. NEVILLE, president-elect, and ANNE HOPKINS, secretary-treasurer.

CURTIS G. HAMES, Claxton, attended the annual meeting of the American Heart Association and the American Society for the Study of Arteriosclerosis.

LEE HOWARD, JR., Savannah, has been named to direct the newly set-up residency training program in pathology at Memorial Hospital in Savannah. The announcement of the favorable action of the A. M. A. Council on Medical Education and Hospitals was made early in January; the department was eligible for accreditation in November. Dr. Howard is a graduate of Duke Medical School and received his residency training in pathology at Duke Hospital. He has practiced in Savannah since 1949. He took over the direction of the department of pathology at Memorial Hospital in September 1955.

W. D. LUNDQUIST, Savannah, addressed a recent meeting of the Optimist Club. He spoke on the functions of the public health service, of which he is an officer.

J. C. METTS, Savannah, in addressing the Savannah Rotary Club, told of the creation, operation, and future plans of the Memorial Hospital of Chatham County. Dr. Metts at the time was chief of the medical staff and a member of the Memorial Hospital Authority. E. CARSON DEMMOND, Savannah, president of the club, presided at the meeting.

CHARLES L. PRINCE, Savannah, has been elected chief of the staff of Memorial Hospital to succeed JAMES C. METTS. Other officers elected include: JULES VICTOR, JR., vice-president; and WILLIAM H. FULMER, secretary-

(Personals)

treasurer. Chiefs of service are as follows: THOMAS A. McGOLD-RICK, internal medicine; ROBERT GOTTSCHALK, surgery; M. M. SCHNEIDER, obstetrics and gynecology; E. N. GLEATON, pediatrics; GRANT W. GOLDENSTAR, eye, ear, nose, and throat; LAWRENCE W. SALTER, general practice; and T. A. Grant, D.D.S., dentistry.

PETER L. SCARDINO, Savannah, was chairman of the Savannah Cancer Seminar held at 612 Drayton Street, Savannah, on January 17, 1957. He is Chairman of Professional Education for the Chatham County Unit of the American Cancer Society. Appearing on the program were the following visiting physicians: Carl Feind, Charles Findley, F. P. Herter, Perry Hudson, Saul Gusberg, and C. D. Haagensen.

Second District

JAMES R. PAULK, Moultrie, has been elected president of the Moultrie Chamber of Commerce for 1957. The newly elected president has been a resident of Moultrie more than 21 years, and has been active in many civic and religious affairs. He is a member of Colquitt County Medical Society.

Third District

CLARENCE G. BUTLER, Columbus, has been named regional co-chairman of the 1957 Georgia Heart Fund Drive. Dr. Butler is a member of the Georgia Heart Association Board of Directors and one of the eight regional co-chairmen. Other physician co-chairmen are HARRY T. HARPER, JR., Augusta, and ARTHUR M. KNIGHT, JR., Waycross.

JOHN K. DAVIDSON, Columbus, spoke at a recent meeting of the Kiwanis Club on the detection of diabetes and its control. LUTHER H. WOLFF, Columbus, is president-elect of the local Kiwanis.

F. D. EDWARDS, Columbus, has been elected St. Francis Hospital chief of staff. Others elected to the medical staff for 1957 were W. E. MAYHER, vice chief of staff; and BRENT FOX, secretary.

A. J. KRATVIN, Columbus, chairman of the diabetes detection drive sponsored by the Muscogee County Medical Society, has an-

nounced that tests were made on 2,347 test strips that were returned to the Muscogee Health Department. Of those, 47 were positive. Beginning in January plans were put into effect to test large industrial groups in Columbus, and the drive will continue indefinitely.

J. C. LOGAN, Plains, has been elected to his second two-year term as mayor of Plains, it has been announced. Dr. Logan became mayor in October 1954, filling out an unexpired term; he ran for and was elected to a full term for 1955-56. During his term of office, much progress has been made in the town, and in a "Better Hometown" contest sponsored by the Georgia Power Company, Plains won two first places and two second places in its population division for total prizes of \$1,000. Dr. Logan, in addition to his civic activities, has practiced medicine for 54 years.

Fourth District

The Meriwether County Hospital Authority has appointed the following physicians to the medical staff of the Meriwether Memorial Hospital: V. H. BENNETT, Gay; W. P. KIRKLAND, H. C. JACKSON, JAMES W. SMITH, JR., and J. A. JOHNSON, SR., all of Manchester; JACK WHITWORTH, Greenville, and W. J. BRADLEY, III, Woodbury.

A. P. JONES, Griffin, has been elected president of the Griffin-Spalding County Hospital medical staff. WELDON KELLEY is the new president-elect, and JOHN E. CLOUSE is secretary.

Fifth District

A. J. CRUMBLY, Atlanta, was certified by the American Board of Surgery on March 13, 1956, and he became a member of the American College of Surgeons in October of 1956. The *Journal* regrets that notice was not given to these two facts earlier.

ROGER DICKSON, Atlanta, was the guest speaker at a recent meeting of the Cobb County Chapter of the Georgia Association for Retarded Children. He discussed some of the causes of retardation, explaining that the most common causes are related to the function of the thyroid gland, the Rh factor, organic brain diseases, encephalitis, lead poisoning, and cerebral hemorrhage at birth.

EUGENE B. FERRIS, Atlanta, has been named medical director of the American Heart Association, effective February 1, 1957. In his new post he will supervise the program of research, rehabilitation, and community service of the American Heart Association. Dr. and Mrs. Ferris will make their home in New York.

JOHN WILLIS HURST, Emory University, assistant professor of medicine, has been named chairman of the department of medicine at Emory University School of Medicine. He succeeds EUGENE B. FERRIS in that office.

C. E. IRWIN, Atlanta, addressed a joint session of the medical staff of Memorial Hospital of Chatham County and the Savannah Surgical Society in Savannah in December. He showed a film and spoke on the rehabilitation of the hand. Dr. Irwin is now in private practice in Atlanta but was, until 1955, medical director at Warm Springs; he is best known for his work in the rehabilitation of the hand crippled by polio. PETER L. SCARDINO, Savannah, has been elected president of the surgical society and J. L. ALEXANDER is program chairman for the hospital medical staff.

Frederick B. Jones, Decatur, is now associated with C. E. CUNNINGHAM, R. P. SHINALL, and JOHN P. HEARD, at the Decatur Clinic, 231 East Ponce de Leon Ave., Decatur. He specializes in obstetrics and gynecology. Dr. Jones is a native of Rockport, Ind., and attended the University of Alabama. He served with the Army Air Corps as a fighter pilot, attaining the rank of lieutenant colonel. Dr. Jones received his M.D. degree from Tulane Medical School and interned at Gorgas Hospital, Canal Zone. He received his training in obstetrics and gynecology at Charity Hospital in New Orleans.

A. H. LETTON, Atlanta, was a member of a panel discussing "Surgical Abdomen" at the Mid-Atlantic Region Surgical Meeting of the International College of Surgeons, held at White Sulphur Springs, West Virginia, February 10-13.

W. A. MENDENHALL, Chamblee, has announced that the Chamblee Hospital and Clinic will close on March 1, 1957. The clinic has been owned and operated by Dr.

(Personals)

Mendenhall since 1941, and its closing will mean the end of emergency hospital service for the North DeKalb area. Four doctors, Dr. Mendenhall, T. Q. SPITZER, JOHN SCHREEDER, and WILLIAM K. KERR, will continue to have their offices in the building, but the clinic policy of having one of the four on call at all times will be discontinued.

DAVID HENRY POER, Atlanta, has been made a member of the A. M. A. Council on National Defense.

J. ELLIOTT SCARBOROUGH, Emory University, has been named by members of the Emory University Clinic to the post of director. He has also been appointed director of professional services in the Emory University Hospital. Dr. Scarborough was formerly director of the Robert Winship Memorial Clinic in the hospital. He succeeds R. HUGH WOOD as director of the clinic.

R. HUGH WOOD, Emory University, according to announcement released by the university, has given up his administrative duties with the Emory University Clinic for health reasons but will continue full time relationship with Emory as a professor of medicine and a member of the medical staff of the clinic. Dr. Wood was for 10 years dean of the medical school, a position he held until last year; and he was named clinic director in 1953.

Sixth District

Members of the Macon Ballet Guild heard WALTER BARNES, Macon, speak on "The Fundamentals of Correct Posture and the Physique of a Dancer" at their January meeting. Dr. Barnes illustrated his talk with film strips and by demonstrations given by members of the Ballet Guild.

ALLAN A. COLE, Macon, has assumed his duties as assistant medical director of the Macon Hospital. Dr. Cole is continuing his own private practice unchanged, but at the hospital is responsible for the intern teaching program. Dr. Cole has been on the medical staff since 1946 and prior to that time was located in Warner Robins where he was chief of medicine at the Regional Hospital from 1942 to 1945.

JOHN I. HALL, Macon, slipped on a wet floor at Macon Hospital and fractured his kneecap in December. Dr. Hall, an orthopedic surgeon, was making the rounds of his patients when the accident happened. He stayed on the orthopedic floor longer than he had planned to.

HOWARD J. WILLIAMS, Macon, has been named a new staff member at Parkview Hospital, and LON KING, SR., has been elected president of the Parkview staff. DEVERAUX JARRATT, Macon, was named vice-president of the staff, and JOE W. DANIEL, secretary. Members of the Parkview executive board include O. F. KEEN, SAM PATTON, E. C. McMILLAN, and Dr.'s Phillips, Daniel and Jarratt.

Seventh District

RALPH W. FOWLER, Marietta, has been named chairman of the nine-member authority that governs operation of Marietta's 155-bed Kennestone Hospital.

JOHN W. LOOPER, Dalton, spoke at a recent meeting of the City Park P-TA. He stated that the number one killer of children is accidents. "Accidents are more of a menace to our children than the next two leading diseases," he said. Dr. Looper's speech was built on the theme, "Key to Your Child's Health."

FLOYD W. MORGAN, Douglasville, won the special election held in December for membership on the Douglas County Board of Education, District Number One, by a margin of over 100 votes. At the first regular meeting of the Board, he was elected chairman and will hold this position for the next four years.

GEORGE C. VASSEY, Rossville, has been elected chief of staff of Tri-County Hospital at Fort Oglethorpe. FRANK L. O'CONNOR, Rossville, is assistant chief of staff, and LE BRON ALEXANDER, Rossville, is secretary.

Eighth District

C. S. BRITT, Brunswick, has been re-elected president and chief of staff of the Brunswick Hospital. Other officers re-elected to fill their former posts are FRANK MITCHELL, vice-president; W. O. INMAN, JR., secretary; and JOHN HIGHTOWER, executive committee member.

Carl W. Lupo, St. Simons, announces the opening of his office for the practice of otology, rhinology, and laryngology in the Marshall Building, Ocean Boulevard, St. Simons. Dr. Lupo is a native of Dooly County; he obtained his M.D. degree from Vanderbilt University in 1917 and served in the Army Medical Corps in World War II and the Korean conflict. He practiced in Brooklyn, N. Y., from 1924 until recently with the exception of the time spent in the service. He is a member of the American Academy of Ophthalmology and Otology and a fellow of the American College of Surgeons.

Ninth District

Dr. and Mrs. ROBERT A. BURNS, Blue Ridge, announce the birth of a son, Robert A. Burns, Jr., on November 16, 1956.

MARCUS MASHBURN, JR., has been elected mayor of Cumming, defeating the incumbent by a margin of 313 to 298 votes. The former mayor had held the office for 27 years. MARCUS MASHBURN, SR., also of Cumming, was re-elected to the state senate.

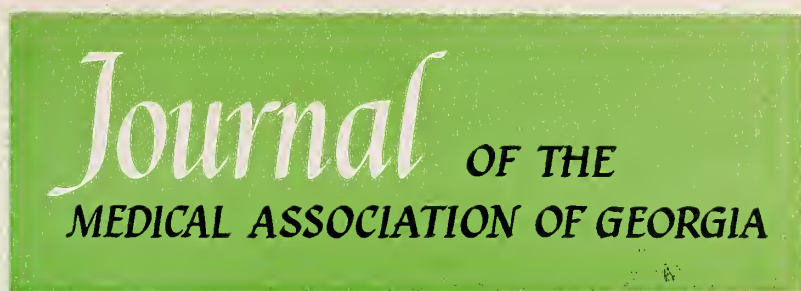
Tenth District

HARRY L. CHEVES, SR., Union Point, has been elected mayor of Union Point by an overwhelming majority. He polled 404 votes to 183 for his opponent. Dr. Cheves campaigned on a promise to try to bring new industry to Union Point.

EDWIN C. JUNGCK, Augusta, attended a meeting of ISSAQUENA—Sharkey-Warren County Medical Society at Vicksburg, Miss. He presented a paper on "Study of the Intersexes."

At the annual meeting of the New York Academy of Sciences, December 6, 1956, V. P. SYDENSTRICKER, Augusta, was elected to fellowship in the Academy. Dr. Sydenstricker is dean of postgraduate medical education and professor and chairman of the department of medicine at the Medical College of Georgia.

W. JOE WILLIAMS, Augusta, has become affiliated with Bankers Fidelity Life Insurance Company as a member of the Board of Directors. The company, made up entirely of Georgia people, plans an active program of expansion throughout the Southeast.



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COVER

Shown on the cover is the lion on the Hotel DeSoto's facade—urging all members to come to the 1957 MAG Annual Session, Hotel DeSoto, Savannah, April 28-May 1, 1957.

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Complicated Fractures of the Femur, Intramedullary Nailing with Supplementary Fixation

ROBERT E. WELLS, M.D., and F. JAMES FUNK, JR., M.D., Atlanta, Ga.

A LARGE INSURANCE CARRIERS' reserve chart indicates that \$2,500.00 is the average figure for compensation and medical expenses for fractures of the femur. This figure is an average for all fractures of the femur. It represents only the financial outlay for medical care and other compensation expenses and does not, of course, measure the loss of industrial productivity or the many inconveniences, both physical and financial, endured by the injured man and his family. Any therapeutic measures which will lessen these problems should be earnestly sought. The use of intramedullary fixation has done much to lessen many of these factors. Methods which will safely widen the scope of intramedullary fixation should be encouraged.

A large collection of literature has been accumulated in the last 10 years concerning intramedullary fixation. Some of these articles have made reference to supplementary fixation, but little emphasis has been placed on these measures.

Advantages

Internal fixation of shaft fractures of long bones by means of medullary canal rods of various types offers many distinct advantages. Primary among these is the elimination of external immobilization or traction devices, allowing earlier mobilization of the adjacent joints and their activating musculature. This shortens convalescence, in many instances by at least half that required without intramedullary fixation; and it significantly lessens residual disability. Prolonged physical therapy measures to restore atrophic muscles and improve restriction in joint motion are not required.

An acceleration of bone healing is anticipated be-

cause of the impacting force brought about by weight bearing and more normal muscle tonicity. The shorter hospitalization and earlier ambulation are to be desired both economically and therapeutically.

Disadvantages of Intramedullary Fixation

Among the disadvantages of intramedullary fixation are those incumbent upon the open reduction of any fracture. The possibility, at least theoretically, of decreased blood supply subsequent to even limited periosteal stripping and the increased possibility of infection are more than outweighed by the advantages of this procedure.

The principal disadvantage is its limited field of application. The fracture suitable for intramedullary fixation must ordinarily be carefully chosen. It should be limited to a level which allows sufficient projection of the nail both proximally and distally to create maximum stability. This level will usually closely coincide with the narrowest portion of the medullary canal. The architectural design of the rod is utilized to restrict rotation in this confined area.

The control of rotation and distraction are two of the troublesome features inherent in intramedullary nailing. The carefully planned use of supplementary screws or combinations of screws and plates increases the applicability of this method. We have not used circumferential wire loops or other encircling apparati because of their tendency to loosen and slip or slide and the potential danger of circumferential impairment of blood supply if too tightly applied. Their control of rotational stresses is not as accurate as transfixing screws.

Uses of Supplementary Fixation

We have recognized four uses of supplementary fixation. In the oblique or transverse fracture in the

Presented at the Annual Session of the Medical Association of Georgia, May 13-16, 1956, Atlanta, Ga.

distal one-third of the femur, where the medullary canal is widened, the short distal fragment allows less mechanical advantage for the control of the fracture position. The use of at least two screws, or frequently a four or six hole plate with screws, effectively controls rotational stresses allowing the purchase of the intramedullary nail in the cancellous bone of the distal fragment to control angular strains.

Butterfly or signet ring fragments can effectively be fixed to the remainder of the shaft thus greatly increasing the stability of the fracture.

More extensively comminuted fractures can be treated by intramedullary nailing if supplementary fixation is utilized. The number of screws utilized depends on the individual fracture but, in general, two screws should enter each major fragment. The stability of the fixation should be carefully evaluated prior to closure of the incision, and, if fixation is not entirely secure, balanced suspension should be utilized for 10 to 14 days postoperatively.

One of the more interesting applications of this particular use of supplementary fixation has been described by McBride in 1953 of a severely comminuted fracture of the middle and distal thirds of a femur.

Segmental fractures, particularly those in which the intermediate fragment is split longitudinally are most difficult problems. Frequently the split fragment can be reassembled with two or three screws and then threaded onto a nail as a single fragment. Of course, care must be taken to assure an extramedullary position of the transfixing screws.

Street has recommended an additional use for supplementary fixation, i.e., those fractures of the femur, particularly in more aged individuals, in which the medullary canal is 15 millimeters or wider in its narrowest portion. This is certainly a valid use of the

principle but we have not had occasion to use it. Another effective means of controlling rotation in these difficult fractures is the use of two nested clover leaf nails of varying diameter.

A word of caution should be interjected. The use of screws can certainly be overdone. Their injudicious use can produce an undesirable result which goes beyond the appearance of amateurish carpentry on the x-ray. No metal as yet engineered for surgical purposes is completely inert. The foreign body reaction attendant on an overabundance of metallic appliances adjacent to a fracture can result in a definite retardation of fracture healing. Each screw should be carefully placed to produce a maximum of stability with a minimum of metal. The screws should invariably be of the same material as the intramedullary rod.

Summary

It is widely agreed at the present time that intramedullary fixation has been very advantageous in lessening the economic and physical disadvantages of many fractures, particularly fractures of the femoral shaft. We have discussed the use of supplementary fixation with screws or plates-and-screws to widen the scope of applicability of intramedullary fixation. Four groups of fractures in which this principle is useful have been suggested.

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The Medical Association of Georgia

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Preliminary Report on the Use of Meprobamate for Pre-Anesthetic Sedation

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SOUND, UNTROUBLED SLEEP the night before operation is essential to the surgical patient. Well rested after suitable premedication, he should arrive in the operating room in a quiet, relaxed state, without anxious awareness of his environment, and undisturbed by the routine preparations for surgery. However, the premedicants commonly employed have fallen far short of the ideal because of delay in onset of sedation, undesirable depression of vital functions, and certain other drawbacks. Newer compounds with superior tension-relaxing and soporific effects recently have been introduced; these appear to afford a more natural sleep than the forced hypnosis induced by the conventional drugs.

The dicarbamate of 2-methyl-2-n-propyl-1, 3-propanediol,¹ or meprobamate,* synthesized as one of a series of propanediols,² is described as possessing definite sedative and muscle-relaxant properties. The pharmacological effects are produced by selective blocking of the long interneuronal circuits concerned with psychic activity and skeletal muscle tonus, and appear with relative promptness.^{1, 3} In the spinal cord the action of meprobamate resembles that of mephenesin, but it is characterized by greater potency and a duration of effect that is prolonged far beyond the response to mephenesin.^{1, 3, 4}

In the higher centers the activity of meprobamate is totally unlike that of any other tension-relaxing agent known. The electroencephalographic patterns indicate definite synchronization of the brain waves, with moderate slowing in frequency.⁴ The effect is most pronounced on the subcortical structures, as the thalamus, and is also apparent in the tracings of the cortex. According to all laboratory and clinical data^{1, 3-8} so far available, there is no alteration of autonomic function. The cardiovascular, respiratory, and gastric secretory mechanisms and the excretion of sweat are not disturbed, nor is there any effect on the peripheral nerves or the myoneural junction. There has been no evidence of chronic toxicity in animals.^{1, 3}

Method

Sedatives were administered, in this investigation, to 132 consecutive patients (98 females, 34 males) on the evening before surgery. The subjects were selected only on the basis of age and presence or absence of treatment orders that might interfere with accurate evaluation of the preoperative sedation obtained. The youngest patient was 16; the oldest, 65 years old.

The series was divided into four groups (Table 1); in each group the patients received a different type of medication. The first 99 patients were integrated into the first three groups in one-two-three order; that is, patient No. 1 received Group 1 medication, patient No. 2 received Group 2 medication, patient No. 3 received Group 3 medication, and so on. The last 33 patients, who received Group 4 medication, were collected separately after the first three groups had been completed.

Group 1 consisted of 33 patients with a mean age of 36.3 years. Each received 100 mgm. secobarbital at 9 p.m.

Group 2 comprised 33 patients with a mean age of 41.2 years, each of whom received 400 mgm. meprobamate at 6 p.m. and 9 p.m. At the 9 p.m. dose, 100 mgm. secobarbital was added to the medication.

Group 3 included 33 patients with a mean age of 40.4 years, who received 400 mgm. meprobamate at 6 p.m. and the same dose again at 9 p.m., but no barbiturate was added.

For Group 4, consisting of 33 patients with a mean age of 40.1 years, two tablets (a total of 800 mgm.) meprobamate were administered in a single dose at 9 p.m., also with no additional hypnotic.

On the day of operation all received routine pre-anesthetic medication. As each arrived at the surgical suite, he or she was questioned as to the sleep obtained the preceding night.

For a representative number in each of Groups 1, 2, and 3, and for all of Group 4, the blood pressure on arrival at the operating room was compared with the blood pressure on admission, and the reduction in blood pressure levels was averaged for each group.

From the Department of Anesthesiology, Medical College of Georgia, Augusta, Georgia.

Read before the 10th Annual Meeting of the Southern Society of Anesthesiologists, Augusta, Georgia, March 29-31, 1956.

*Equanil® Tablets (Meprobamate) were supplied by Wyeth Laboratories.

Results

Group 1 (secobarbital only, at 9 p.m.). Fifteen patients (45 per cent) slept all night. Blood pressure readings were taken for 18 of this group. The average fall in pressure was 12.3 per cent.

Group 2 (two evening doses of 400 mgm. meprobamate three hours apart, and secobarbital with the last dose). Twenty-five patients (above 75 per cent) in this group slept all night. Blood pressure readings were taken for 17 patients; the fall in pressure averaged 14.9 per cent.

Group 3 (two evening doses of 400 mgm. meprobamate three hours apart). Eighteen patients (54 per cent) obtained a full night's sleep. Blood pressures were determined for 17 of this group. The average fall was 16.7 per cent.

Group 4 (a single 800 mgm. dose meprobamate at 9 p.m.). Twenty-four patients (about 73 per cent) slept all night. Blood pressures were determined on admission and immediately before operation for all of this group. The average fall was 10.9 per cent.

No allergic or other side actions were observed in the entire series.

Discussion

The notable finding in this study is that essentially the same percentage of patients slept well on two tablets (800 mgm.) meprobamate given as a single evening dose as did those who received two smaller evening doses of meprobamate three hours apart, the last dose being given in combination with secobarbital. These data suggest that when meprobamate is administered in an adequate amount for preoperative sedation, addition of a barbiturate the evening before surgery may be unnecessary.

The average reduction in blood pressure after meprobamate medication did not exceed the fall in pressure that occurs after use of the common preoperative sedatives.

Selling,⁵ Borrus,⁶ and Lemere⁷ have reported significant relief of psychic tension, after treatment with meprobamate, in various types of neuroses and anxiety reactions. In Selling's series, consisting of 187 patients, the compound produced no toxic symptoms. Allergic side actions were observed in three, and five experienced some gastric discomfort. Thal⁸ also has described medication of psychotic patients with the compound in preparation for electroshock, and he states that "very impressive" alleviation of preshock apprehension and agitation was obtained.

The clinical picture that emerged from the current series was similar to that described by other investigators.⁵⁻⁸ A larger percentage of the patients sedated with meprobamate slept soundly throughout the night than was true of the control group who had received only the usual light, short-acting barbiturate. On reaching the operating theater, the meprobamate-treated patients did not exhibit anxiety and apprehension to the degree commonly seen in those brought to surgery after the conventional sedation.

Summary

A series of 132 surgical patients, divided into four groups, received various drugs or combinations of drugs for preoperative sedation.

Thirty-three received 100 mgm. secobarbital at 9 p.m. the night before surgery; 33 received two evening doses of 400 mgm. meprobamate three hours apart, and secobarbital with the last dose; 33 re-

Dose	Secobarbital 100 mgm, 9 p.m.	Meprobamate 400 mgm, 6 p.m. and 9 p.m. Secobarbital 100 mgm, 9 p.m.	Meprobamate 400 mgm, 6 p.m. and 9 p.m.	Meprobamate 800 mgm, 9 p.m.
No. of observations	33	33	33	33
Sex	Females 22 Males 11	Females 25 Males 8	Females 26 Males 7	Females 25 Males 8
Age range	20-64	18-64	18-63	16-65
Mean age	36.3	41.2	40.4	40.1
Slept all night	15 (45%)	25 (75%)	18 (54%)	24 (73%)
% reduction of blood pressure	12.3 (18 cases)	14.9 (17 cases)	16.7 (17 cases)	10.9 (33 cases)

*Blood pressure on arrival at the operating room as compared with admission blood pressure.

Table I

Foundation for Eye Care

ANNOUNCEMENT WAS MADE November 15, 1956, of the establishment of the National Medical Foundation for Eye Care, a non-profit scientific and educational institution, incorporated in New Jersey. The Foundation has been organized by ophthalmologists of the country to provide American ophthalmology with an agency to present to the public generally and to fellow physicians pertinent information on the care and treatment of the eyes.

Ralph O. Rychener, Memphis, Tenn., is president of the Foundation; Edwin Forbes Tait, Norristown, Pa., vice-president, and Charles E. Jaeckle, East Orange, N. J., secretary-treasurer.

Members of the Board of Trustees, in addition to the above named, are: Alson E. Braley, Iowa City, Iowa; Frederick C. Cordes, San Francisco, Calif.; Paul Chandler, Boston, Mass.; J. Spencer Dryden, Washington, D. C.; Harold F. Falls, Ann Arbor, Mich.; Everett L. Goer, Houston, Texas; Erling W. Hansen, Minneapolis, Minn.; A. D. Ruedemann, Detroit, Mich.; Barnet R. Sakler, of Cincinnati, Ohio, and Derrick Vail, Chicago, Ill.

In a special statement announcing the Foundation's establishment, Dr. Rychener declared:

"American ophthalmologists have long recognized an urgent need for an organization whose principal function will be to interpret the basic professional and scientific standards of good eye care for the American people, both to our fellow physicians and to the people whom we serve.

"The National Medical Foundation for Eye Care will seek to serve the public interest by helping the people to understand the educational qualifications and the professional functions of physicians specializing in ophthalmology, and the function of related technical and ancillary personnel who assist them. The Foundation will also endeavor to keep our colleagues in the medical profession informed concerning the problems confronting ophthalmology in its efforts to fulfill its mission as a member of the team of recognized medical specialists serving the American people."

Dr. Rychener revealed that the Foundation is now enrolling its charter membership, and he invited all ophthalmologists and other physicians in-

terested in eye care to become charter members of the Foundation.

Applications are available through Dr. Charles E. Jaeckle, secretary-treasurer, at 136 Evergreen Place, East Orange, New Jersey. The Foundation is establishing an administrative office in New York City, and will make available an Affiliate Membership for persons other than doctors of medicine who are interested in aiding the purposes of the Foundation.

The object and purpose of the Foundation is to advance the public welfare by:

1. Gathering, receiving, assembling and studying information relative to eye care.
2. Fostering and/or engaging in investigations and research in all aspects of eye care.
3. Sponsoring studies of educational, socioeconomic and scientific factors affecting eye care.
4. Issuing reports and otherwise disseminating information relative to eye care to the general public and to members of the medical profession and ancillary workers.
5. Promoting the conservation of vision and the prevention of blindness through the wider dissemination of knowledge of the eye, its defects, disfunctions and other diseases and their relation to general health.
6. Promoting a more effective utilization of the scientific knowledge of ophthalmology and the other related branches of medicine.
7. Generally performing any act, related to the foregoing, designed to present to the public generally and the medical profession, all pertinent information on the care and treatment of the eyes.

... Meprobamate for Pre-Anesthetic Sedation (cont'd)

ceived a single dose of 800 mgm. meprobamate at 9 p.m.

The findings in this study suggest that when meprobamate is administered in sufficient dosage, the barbiturates may be eliminated from the preoperative medication the evening before surgery. The average reduction in blood pressure, from the day of admission to the morning of operation, did not exceed the fall normally to be expected as a result of sedation.

University Place

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The Prevention and Inhibition of Postpartum Lactation

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THE ROLE OF HORMONES in the inhibition or arrest of lactation has not been fully accepted. There are those who feel that breast binders, aspirin, and epsom salts is a regimen of therapy sufficient unto itself; and there are those who feel that hormones are incapable of influencing lactation. The polemics for or against the necessity of arresting lactation are not within the scope of this paper. It is our purpose to establish the fact that the proper use of steroids is attended by satisfactory prevention of lactation, or arrest of lactation when it has already been established.

Heretofore the experiences of many physicians who have used estrogens frequently proved less than satisfactory for various reasons.

(1) Estrogens, in too small dosage, were started after lactation was already established and the results were too variable.

(2) Estrogens were administered for too short a period of time, with temporary cessation of lactation, only to recur a few days after therapy was stopped.

(3) A frequent complication was excessive postpartum bleeding.

The objections outlined above may be readily circumvented if

(a) Adequate steroid therapy is started immediately postpartum whenever possible.

(b) The dosage so administered that recurrence of lactation does not occur as a withdrawal effect. (This can be accomplished by giving the hormone in descending doses over a period of 21 days, or by giving a long-acting estrogen over a period of seven days.)

(c) Withdrawal bleeding can be minimized if an androgen is added to a long-acting or slowly excreted estrogen.

To meet these requirements, one of the pharmaceutical houses prepared for us a capsule containing a slowly excreted estrogen, chlorotrianisene (TACE)

6.0 mg., with methyl testosterone, 2.5 mg. (TACE with Androgen). Eight such capsules were administered (two capsules four times daily) for seven days to 28 patients on the first or second day postpartum in an effort to prevent lactation; and to 11 patients to arrest lactation after it had been well established for five to 30 days postpartum. The results are outlined in Charts I and II.

In contrast to our previous experiences over the past dozen years, it was felt that this regimen of therapy was, with few exceptions, so good that it is our considered opinion that a worthwhile combination is now available for use in the management of this problem.

Explanation of Results

We readily concede that the dosage requirement for some patients may vary from the schedule chosen for study; however, by trial and evaluation, this regimen was found to be adequate for most patients (Charts I and II). No breast binders, fluid restriction, or other adjunctive therapy was used.

Prevention of Lactation

Twenty-eight patients were given two TACE with Androgen capsules four times daily for seven days beginning on the first or second day postpartum to prevent lactation (Chart I). No evidence of lactation or breast congestion occurred in any of these patients during the week of therapy. In eight of these patients breast engorgement and lactation were simply delayed and occurred four to six days after the termination of therapy. Five of these were mild and self-limited. In three patients the breast discomfort required a second course of therapy, and all responded satisfactorily to one capsule three times daily for seven days. All patients included in this study were asked to call immediately if any bleeding occurred within four weeks after delivery, and all were questioned carefully about bleeding at the time of the six weeks examination. Four of the 28 patients reported vaginal bleeding which began five to seven days after completion of therapy and lasted for six to seven days. The bleeding was mild in all cases, and no specific therapy was required.

From the Department of Endocrinology, Medical College of Georgia, Augusta.

Supplies of medications used in this study were provided by the Wm. S. Merrell Company, Cincinnati, Ohio. (Chlorotrianisene—TACE; Chlorotrianisene with Methyl Testosterone—TACE with Androgen).

TACE WITH ANDROGEN — TO PREVENT LACTATION

No. Patients	Therapy Begun	Dosage	Effect on Lactation:			
			Complete Suppression	Temporary Suppression (lactation occurred after therapy)	Required 2nd Course of Therapy (3x7 days)	Withdrawal Bleeding
28	1st or 2nd day post- partum	2 caps. daily for 7 days	20	8	3	4*

*Occurred in all instances 1 week after therapy and lasted 7 days. None required therapy.

Chart I

Arrest of Established Lactation

For various reasons it frequently becomes necessary to stop nursing after lactation has become well established. Systemic illness, excessive breast engorgement, fissured nipples, and breast abscess are a few such indications. Eleven patients, in whom lactation was well established, were given TACE with Androgen capsules according to the same dosage schedule. The time of beginning therapy varied from the fifth to the thirtieth day postpartum. Without the use of binders, ice bags, or fluid restriction, eight of these 11 patients reported excellent and immediate relief of breast congestion. No pumping of the breasts was used, and nursing was stopped abruptly. During the seven days of therapy lactation subsided, and none of these patients reported recurrence of lactation following therapy. Two patients reported continued engorgement of the breasts and severe discomfort during the first four days of therapy although lactation gradually subsided after this, and no further therapy was required. Although it was eventually adequate, we have termed the response in these patients "slow." Lactation and breast engorgement, although less painful, persisted throughout the week of therapy in one patient. This patient responded satisfactorily to a repeat course of therapy consisting of two TACE with Androgen capsules three times daily for another seven days.

Although it is difficult to quantitatively evaluate bleeding during the puerperium, there was no evidence that any of the patients treated gave a bleeding history which differed from the usual in postpartum patients.

No untoward effects of therapy such as nausea, hoarseness, hirsutism, or acne were noted in any of the patients studied, although all were questioned and observed specifically for these conditions.

Discussion

No method yet reported for suppression of lactation in the postpartum patient has proved entirely satisfactory. Estrogens alone, over the years, have given variable and far less than satisfactory results. Hesseltine and associates¹ recently reported unpredictable response to diethylstilbestrol in 153 patients and concluded that the influence of diethylstilbestrol on lactation was limited. Estrogen-androgen combinations have been effectively used to prevent initial painful breast engorgement.² A single intramuscular injection of 100 mg. testosterone cyclopentylpropionate administered during labor or shortly thereafter was found to be satisfactory in initiation of lactation control in 90.4 per cent of 125 patients.³ Our experiences with this method have been less successful, although it has proved useful when delay in the onset or temporary suppression of lactation was desired.

In our experience, diethylstilbestrol and other estrogenic substances, when given in adequate dosage over a sufficient period of time, can adequately suppress lactation in the majority of patients. When used in this manner, however, the most serious undesirable effect of therapy—withdrawal bleeding—is believed due to the short duration of action and sudden lowering of blood estrogen levels. The introduction of chlorotrianisene (TACE) offered an oral estro-

TACE WITH ANDROGEN — TO ARREST ESTABLISHED LACTATION

No. Patients	Therapy Begun Postpartum	Dosage	RESULTS			Withdrawal Bleeding
			Relief of Congestion — Excellent	Slow	Cessation of Lactation No Response	
11	5 to 30 days	8 caps. daily x 7 days	8	2	1 (responded to repeat course of same therapy)	None

Chart II

genic substance which is stored in fat tissues of the body^{4, 5} and, due to its slow release into the blood stream, allowed prolonged action and a more gradual reduction in blood estrogen levels. Hendricks⁶ administered TACE, 12 mg. four times daily, to 60 postpartum patients and reported complete inhibition of lactation in 50 patients. He also observed, however, that TACE, in this dosage, proved ineffective in arrest of lactation when therapy was started as late as the third or fourth postpartum day. He reported no increase in the incidence of postpartum bleeding after TACE therapy.

Our own experience with chlorotrianisene (TACE) alone was equally satisfactory to that of Hendricks. Of 61 patients who received 12 mg. TACE three times daily for seven days, initial suppression of lactation was satisfactory in 56 patients. When lactation was well established, however, results were variable with this dosage. We found that two 12 mg. capsules TACE three times daily for 10 days gave more satisfactory results in nursing patients or when onset of therapy was delayed longer than three days postpartum. Withdrawal bleeding which required active therapeutic measures occurred seven to 10 days after therapy in six of 31 patients with this dosage schedule, whereas with the TACE with Androgen combination, bleeding, when it did occur, was minor and self-limited. Although this report embraces our experiences in the inhibition of lactation in 100 patients, we were most impressed by the effectiveness and significant absence of withdrawal bleeding with the TACE with Androgen combination. Since lactation recurred in a few patients after completion of therapy with the dosage used, a short course of therapy (three or four days) may be useful at times when temporary suppression of lactation is desired.

Summary

1. This report presents our experience with chlorotrianisene (TACE) and chlorotrianisene with

methyl testosterone (TACE with Androgen) for inhibition of lactation in 100 postpartum patients.

2. In some patients simple measures such as breast binder, ice bags, fluid restriction, epsom salts, and aspirin suffice. Occasionally mammary congestion and engorgement are so severe that these simple measures leave much to be desired.

3. The inadequacies of the time-honored use of diethylstilbestrol and other estrogenic substances are pointed out.

4. Use of a new synthetic estrogen which is stored in fat tissues and released gradually, resulting in longer action and more gradual reduction of blood estrogen levels, reduces the incidence and severity of uterine bleeding following therapy. Results with this synthetic estrogen when used in combination with methyl testosterone (TACE with Androgen) for prevention and suppression of postpartum lactation were so good that it is our considered opinion that a worthwhile oral combination is now available for use in management of this problem.

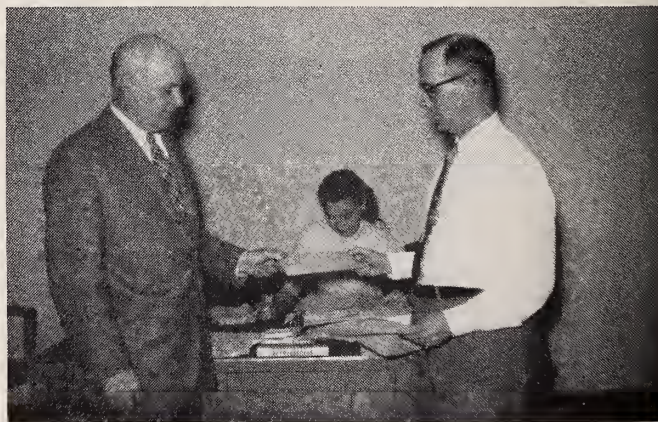
Medical College of Georgia

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First Medicare Check Paid

Pictured on the right is Mr. Dougald Avera presenting to Eugene Griffin, Atlanta, the first check made in payment under the new "Medicare" plan. Claims have been submitted by 362 physicians; to date \$35,000 has been paid in Medicare claims, and 763 claims are in the process of being cleared for payment. Also pictured is Mrs. Jean Buice, secretary and assistant to Mr. Avera in the Medicare Department. Mrs. Buice is a native Atlantan and a registered nurse, having graduated from Georgia Baptist Hospital School of Nursing. She was formerly employed in a physician's office. Mrs. Buice joined the staff of the MAG in February.



Dr. Griffin, Mrs. Buice, Mr. Avera

Current Status of Topically Applied Hydrocortisone and Its Analogs

C. CONRAD SMITH, M.D., Augusta, Ga.

AS STATED BY SULZBERGER,¹ "living human skin probably excels all other organs as an instrument for assaying certain effects of agents intended for use upon man." By use of the method of symmetrical paired comparison, the adrenal corticosteroids and their derivatives are especially suitable for evaluation of their topical effectiveness. In using this method of comparison, clinical investigators have evaluated the effects of hydrocortisone ointments and lotions^{2, 3} by application to diseased skin on one side of the body and compared them with the effect of ointment or lotion base alone on the affected areas of the contralateral side. Having established the value and effective concentrations of topically applied hydrocortisone, this agent could then be used to evaluate the relative topical effectiveness of the newer analogs of hydrocortisone by this same method of symmetrical paired comparison.

Cortisone when topically applied was found ineffective in the treatment of skin disease, with the possible exception of certain skin eruptions at the mucocutaneous junctions. Topically applied hydrocortisone, by contrast, has been shown to be effective in a variety of skin diseases including atopic dermatitis, allergic eczematous contact dermatitis, and certain other eczematoid skin diseases, anogenital pruritus, otitis externa, eyelid dermatitis, localized neurodermatitis, and some forms of seborrheic dermatitis.

Hydrocortisone free alcohol⁴ is at least as effective as hydrocortisone acetate when applied topically in treatment of skin disease.

In general, a one per cent hydrocortisone ointment or lotion is an adequate concentration for treatment of skin disease in which topical hydrocortisone is effective, although the effective concentration may range from as low as 0.25 per cent to five per cent or more. Ordinarily, if effective, improvement is noticed within 24 to 48 hours after therapy is initiated. In the group of self-limited skin diseases in which topical hydrocortisone is effective, partial to almost complete clearing of the eruption with alleviation of symptoms is maintained by continuing the topical use of the steroid throughout the natural course of the condition. In skin diseases which are not self-limited, the improvement is generally not

maintained when this topical measure is discontinued, the same result as one would expect from systemic administration of the steroid. As a rule in the management of these chronic skin diseases which are not self limited, once the eruption is brought under control, this improvement can be maintained with a smaller amount and less frequent application of the hydrocortisone ointment or lotion.

The untoward physiological effects seen with systemically administered hydrocortisone have not been observed from topically applied hydrocortisone even after prolonged use over large areas of the body. Laboratory procedures^{5, 6, 7, 8} designed to demonstrate systemic absorption from topically applied hydrocortisone have failed to reveal absorption. This indicates no systemic absorption or more probably insufficient absorption to be detected by the tests used.

Recently halogenated derivatives of hydrocortisone, namely chlorohydrocortisone and fluorohydrocortisone^{1, 9} have been found to be effective when topically applied in the same group of skin diseases in which hydrocortisone is effective. Nine-alpha fluorohydrocortisone when applied topically is effective in one-tenth the concentration of topically applied hydrocortisone acetate or free alcohol. There is some clinical as well as laboratory evidence to indicate some systemic absorption from topically applied fluorohydrocortisone.¹⁰

More recently, prednisolone, though requiring only one-third the dose for the same therapeutic response as hydrocortisone when administered systemically, is not effective in the same proportion when applied topically. It is this writer's opinion¹¹ that a one-half prednisolone ointment is not as effective as a one per cent hydrocortisone ointment in treatment of skin diseases.

Though experience is limited at present in the use of more soluble forms of hydrocortisone, such compounds as hydrocortisone hemisuccinate sodium and hydrocortisone diethylaminoacetate hydrochloride used topically in an ointment base apparently reduce the concentration of hydrocortisone necessary for therapeutic effect.¹²

From the rapid advances in this therapeutic field,

for dermatology and medicine in general, one can easily conceive of even greater progress in the future.

Summary

When topically applied to a variety of skin diseases: (1) Cortisone is ineffective with the possible exception of involvement around the mucocutaneous junctions. (2) Hydrocortisone acetate or free alcohol is an effective and most important addition to our therapeutic armamentarium. (3) Nine-alpha fluorohydrocortisone is effective in one-tenth the concentration of hydrocortisone. (4) Prednisolone is effective but probably not in the same ratio as when administered systemically. It is apparent that a one-half per cent prednisolone ointment is not as effective as a one per cent hydrocortisone ointment.

More soluble forms of hydrocortisone such as hydrocortisone hemisuccinate sodium and hydrocortisone diethylaminoacetate hydrochloride, may be as effective as hydrocortisone acetate or free alcohol while requiring less concentration.

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Tranquilizers and Anesthesiology

WHENEVER A NEW SEDATIVE type drug comes on the market, it is always necessary to test its potentialities for improving the present methods of anesthesia. The most recent of these, meprobamate (Equanil or Mil-town), has attracted widespread attention.

The most promising aspect of this drug seems to be in its use in preoperative sedation. Its action is such that it instills a relative "peace of mind" without the necessity of sleep, and consequently without noticeable depression. Its use alone or in combination with barbiturates has served well to render most patients calm and cooperative regarding the induction of anesthesia. It is particularly useful in those patients who begin their state of nervousness at the time they find an elective operation necessary, and it can be given for a period of a week or even 10 days prior to surgery with excellent results. Many times a patient begins to get extremely nervous on admission to the hospital, and these drugs can be given without interfering with the normal course of laboratory work, history taking, etc.

One possible word of warning might be interjected concerning this drug. Recent verbal reports from clinics in which this drug is given for a long period of time, that is six to eight months, indicate that in some instances epileptiform type seizures have been initiated by prolonged administration. To my knowledge, this report has not been issued regarding short term administration. Thus, it would not seem that the drug at present is at all contraindicated for usage before and even after the operative period, but as with other drugs, it would be well to limit its usage to a period of absolute necessity.

Surgery in the Aged

IT IS INTERESTING to note in the literature that the dividing line between middle and old age has been changing over the past two or three decades; formerly the articles referred to old age as that period over 50 years of age while at present old age is thought to start at 60, and many authors predict that the dividing line will be moved up to 70 years within another decade. At present, when we refer to old age or the older age group, we are speaking of people over 60 years of age. Geriatric patients have always been with us and will be with us in increasing numbers in the future. It is remarkable that between 1920 and 1940 the population between 65 and 74 years of age increased five fold over the increase in total population, and the number of people over 75 increased even more rapidly. It has been es-

timated that by 1980, 40 per cent of our population will be over 65 years of age; in view of this it would behoove us as physicians to pay particular attention to surgery in the older age groups since the problems involved in geriatric surgery will present themselves with increasing frequency in future years.

Patients in the older decades of life undergo definite physiological changes which must be understood in order that these patients may be treated intelligently. They have a lower basal metabolic rate than they had when they were younger and therefore tolerate all opiates and sedatives poorly. They will be unduly depressed by the dosages which are routinely given to younger patients. In addition, the blood volume in the geriatric patient is smaller. Berry and Lob showed that blood volume varies from 3,300 to 4,100 cc. in contrast to the average blood volume, 5,500 to 6,000 cc., of younger patients. For that reason these patients cannot tolerate hemorrhage or circulatory overloading as well as younger patients. Because of this, blood transfusions and intravenous fluids should be given more slowly and in smaller amounts.

Protein nutrition in the older patient is often quite poor usually due to inadequate protein intake. This may be due to loss of appetite, poor economic circumstances, or the boredom of preparing one's own meals and eating alone. An adequate dietary history should be taken to aid in predicting the presence or absence of low blood and tissue proteins. The work of Collier and Dobbie has shown that wound healing per se is normal in the older patient if he has a normal tissue protein store and if he is not anemic.

As is well known, the symptoms and signs of disease are apt to be atypical in the aged due to their altered physiology and at times due to their inability, in the presence of cerebral arteriosclerosis, to accurately recount symptoms.

The patient's preoperative evaluation should be more thorough and detailed than in the younger age periods and should probably include a urinalysis, complete blood count, chest x-ray, serum proteins, and, if indicated, an electrocardiogram. Operation should, of course, be based on the principles of good surgery, but, in addition, speed of operation is of more consequence in these patients. Anesthesia should be selected with an eye to giving the patient the maximum oxygenation possible with the degree of relaxation needed for the particular case.

In the postoperative period, fluids should be limited to 1,500 to 2,000 cc. per 24 hours and should be given more slowly than in the younger age group. If the patient is not losing electrolytes by vomiting, diarrhea, fistula, or suction no sodium is needed; however, if there is electrolyte loss, it should be replaced volume for volume. Blood transfusions should be given only if needed and should not exceed 500

cc. in a day unless the patient has lost a great deal of blood. Anoxia is particularly to be guarded against, and probably the cheapest and easiest method of oxygen administration is the nasal catheter. It is particularly advantageous since older patients are often terrified by an oxygen tent. Deep breathing exercises and early ambulation are very important in preventing atelectasis, and opiates and sedatives should be given in very small amounts. It would probably be better to eliminate the barbiturates entirely since they often cause confusion in this age group.

Studies by Mithoefer, by Cole, and by Haug and Dale all have shown not only that elderly patients have a higher operative mortality than those in the younger age groups, but, more important, that emergency surgery in these older patients has a mortality rate of four to six times that of elective surgery. As Coller has so aptly put it, "The emergency surgery of the aged is delayed elective surgery of middle age". Therefore it would behoove us to urge younger patients who need elective surgery not to postpone it until it becomes an imperative procedure in older age.

If we will follow these principles, surgery in the aged will be much safer and more gratifying.

Duncan Shepard, M.D.

Nephrosis

RECENTLY SOME OF THE FASCINATING mysteries of the nephrotic syndrome have been solved. The broad application of some of the answers justifies a brief report here.

For years the relationship of lipid nephrosis to the nephrotic syndrome of glomerulonephritis has been disputed. Vernier and collaborators¹ report four siblings whose kidneys were examined either by open biopsy or autopsy. One had fatal chronic glomerulonephritis, another had transient pure nephrosis, a third had clinical nephrosis with subacute glomerulonephritis pathologically, a fourth had nephrosis from birth, and biopsy showed normal kidney even when special stains were employed. All showed a common lesion in the podocytes or large cells entwined about the glomerular capillaries when examined under the electron microscope. These findings suggest that in many instances "pure" nephrosis and the nephrotic syndrome of glomerulonephritis may be of identical origin.

Nephrotic edema long attributed to low osmotic pressure of the serum produced by hypoalbuminuria with loss of fluid into the tissues is now believed to be caused by salt and water retention from hypersecretion of aldosterone.² The latter is a hormone from the outer layer or glomerulosa of the adrenal cortex which has a sodium-retaining effect one hun-

dred times that of desoxycorticosterone acetate. The trigger mechanism stimulating secretion of this hormone is uncertain but is probably low arterial blood volume secondary to the low serum osmotic pressure. The trigger must be arterial rather than venous blood volume because the same hormone is overactive in heart failure in which venous blood volume is high and arterial blood volume is probably low.

The hyperlipemia and hypercholesterolemia which characterize the nephrotic syndrome have now been proven to result directly from the hypoalbuminuria³. When loss of albumin is prevented in rats with experimental nephrosis by ligation of the ureters or by implantation of the ureters into the inferior vena cava, the hyperlipemia does not occur. Also, when the lost albumin is replaced by a constant intravenous infusion of albumin, the blood lipids do not rise. The exact relationship between blood lipids and albumin is uncertain. Some authorities believe that albumin is involved in the transport of lipids through metabolic pathways. A lipid mobilizing factor has been isolated recently—a single injection of which into human beings produces a rise of 200-300 mg. per 100 cc. in blood cholesterol and a corresponding rise in the lipids within 30 minutes persisting for several days. Prolonged injection produces marked loss of weight and fat depots. No study of this factor in nephroses has been reported thus far.

Good statistics in 500 cases of nephrosis have revealed the deadliness of this disease—a three-year mortality rate of 35 per cent and a four-year mortality rate of 40 per cent.⁴ Steroids in addition to producing a diuresis seem to prevent death from renal failure until nature effects a cure.⁵ Since a planned program of continuous treatment was instituted at Egleston and Grady Hospitals four years ago, there have been no deaths in nephrotic children. Lange in New York has had 24 patients with only one death. Proper management in nephrosis means an effort to render the urine free of albumin as well as rid the patient of edema. Larger doses of steroids than we have been accustomed to giving may be required in resistant patients to achieve this end but we must bear in mind the mortality rate of this disease.

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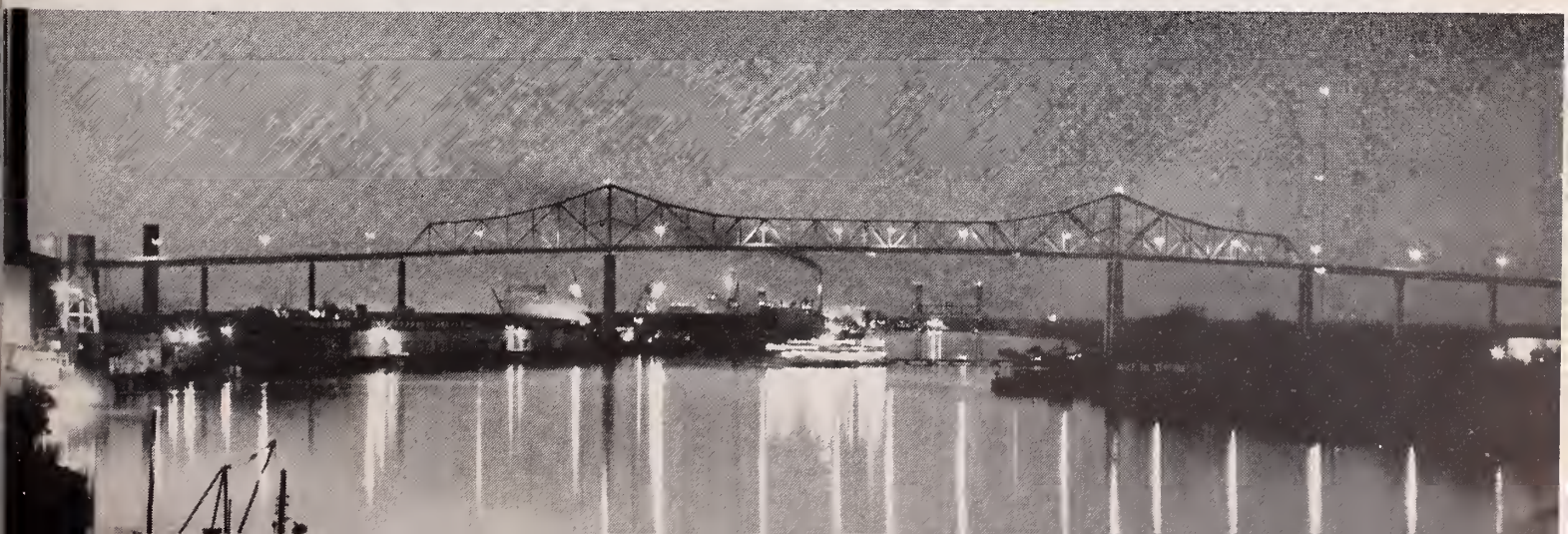


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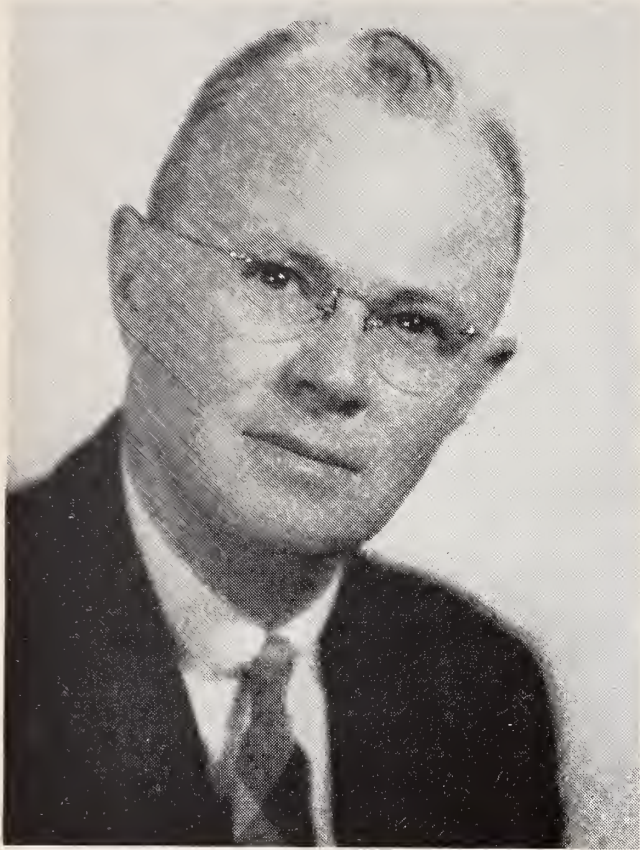
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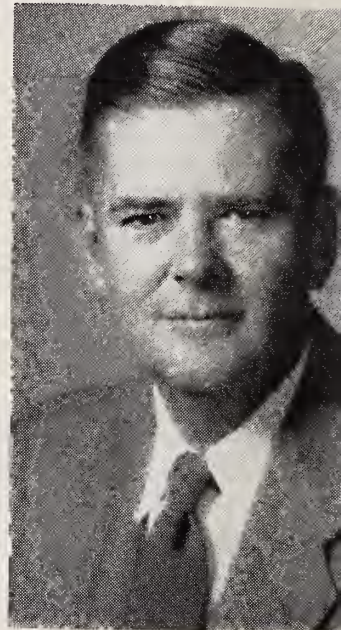
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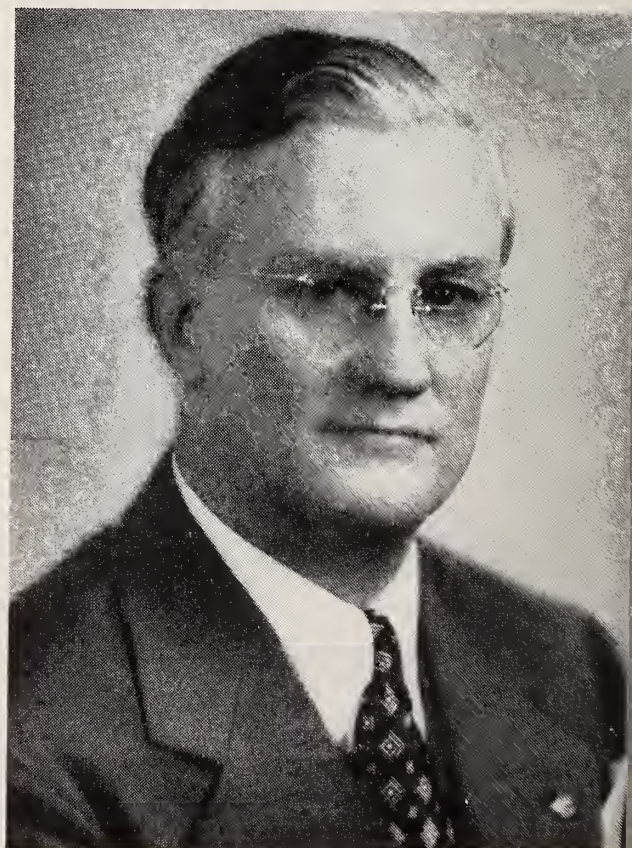
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H. Dawson Allen, Jr., Milledgeville

Public Health

T. A. Sappington, Thomaston, *Chairman*
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Duncan Shepard, Atlanta
Milford B. Hatcher, Macon
M. F. Simmons, Decatur
Edgar M. Dunstan, Atlanta
Rives Chalmers, Atlanta
J. C. Hughston, Columbus
Charles M. Mulherin, Augusta
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Public Service

Chris J. McLoughlin, Atlanta, *Chairman*
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Thomas L. Ross, Jr., Macon
Stephen D. Smith, Rome
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Robert G. Ellison, Augusta

Rural Health

J. L. Walker, Clarkesville, *Chairman*
1st—Charles T. Brown, Guyton
2nd—Henry A. Bridges, Bainbridge
3rd—M. F. Arnold, Hawkinsville
4th—T. A. Sappington, Thomaston
5th—John P. Heard, Decatur
7th—H. C. Derrick, Lafayette
8th—Sage Harper, Douglas
9th—J. L. Walker, Clarkesville
10th—Hugh B. Cason, Warrenton

Scientific Exhibit Awards

Ted F. Leigh, Emory University, *Chairman*
Hoke Wammock, Augusta
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Veterans' Affairs

Hartwell Joiner, Gainesville, *Chairman*
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Woman's Auxiliary

Edgar M. Dunstan, Atlanta, *Chairman*
Shelley C. Davis, Atlanta
R. C. Major, Augusta
Walker L. Curtis, Atlanta
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Interprofessional Council of Georgia

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John Stegeman, Athens
George Mudter, Ph.G., Manchester, *Secretary*
Tyre Watson, Jr., Ph.G., Decatur
F. E. Williams, Ph.G., Statesboro
W. A. Carr, D.D.S., Augusta
Herbert Cohen, D.D.S., Macon
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Medical Advisory to Selective Service

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Carter Smith, Atlanta
Cyrus W. Strickler, Jr., Atlanta
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Chas. C. Rife, D.V.M., Atlanta
Homer E. Nash, Atlanta
Dana Hudson, R.N., Atlanta

First District Advisory Subcommittee

J. C. Metts, Savannah, *Chairman*

William H. Fulmer, Savannah
Oscar H. Lott, Savannah
David B. Fillingim, Savannah
David Robinson, Savannah
J. A. Mooney, Statesboro
Albert M. Deal, Statesboro
Cleveland Thompson, Jr., Waynesboro
A. G. Pinkston, Jr., Glennville
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Second District Advisory Subcommittee

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J. Zeb McDaniel, Albany
John P. Tucker, Bainbridge
Kirk Shepard, Thomasville

Harry B. Baxley, Donalsonville
James R. Paulk, Moultrie
Paul W. Lucas, Tifton
Howard L. Cheshire, Thomasville
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Third District Advisory Subcommittee

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Bon M. Durham, Americus
R. C. Pendergrass, Americus
L. C. Cheves, Montezuma
John E. Smith, Fitzgerald
Maurice F. Arnold, Jr., Hawkinsville
R. B. Martin, III, Cuthbert
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Douglas L. Head, Jr., Zebulon
H. C. King, Griffin
William R. King, Jr., Griffin
V. B. Williams, Griffin
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Fifth District Advisory Subcommittee

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Darrell Ayer, Atlanta
Linton H. Bishop, Jr., Atlanta
Edgar Boling, Atlanta
Charles E. Dowman, Atlanta
Edgar M. Dunstan, Atlanta
William K. Kerr, Chamblee
T. E. McGeachy, Decatur
Edgar D. Shanks, Atlanta
Bernard P. Wolff, Atlanta

Sixth District Advisory Subcommittee

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O. C. Woods, Milledgeville
M. W. Hurt, Sandersville
J. R. S. Mays, Macon
Frank Vinson, Fort Valley
Fred J. Coleman, Dublin
J. P. Woodhall, Macon
W. J. Jordan, Macon
Henry H. Tift, Macon

Seventh District Advisory Subcommittee

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Roy Pope, Jr., Chickamauga
T. A. Cochran, Ringgold
D. L. Wood, Dalton
Charles M. Garland, Jr., Smyrna
Lester Harbin, Rome
John McCall, Rome
Wm. B. Quillian, Cartersville
Alfred O. Colquitt, Jr., Marietta
L. R. Lang, Calhoun

Eighth District Advisory Subcommittee

T. J. Ferrell, Waycross, *Chairman*
A. G. Little, Jr., Valdosta
B. G. Owens, Valdosta
H. L. Moore, Brunswick
Sage Harper, Douglas
S. T. Parkerson, McRae
J. B. Brown, Jr., Baxley
J. W. Yeomans, Jesup
Jesse L. Parrott, Hahira

Ninth District Advisory Subcommittee

Alex B. Russell, Winder, *Chairman*
O. C. Pittman, Commerce
John M. Hulsey, Jr., Gainesville
Edward W. Grove, Gainesville
Robert T. Jones, III, Canton
Chas. R. Andrews, Jr., Canton

Joe J. Arrendale, Cornelia
W. Bruce Schaefer, Toccoa
W. Ben Nalley, Helen
C. J. Roper, Jasper

Tenth District Advisory Subcommittee

M. C. Adair, Washington, *Chairman*
John B. O'Neal, III, Elberton
H. L. Cheves, Union Point
A. S. Johnson, Sr., Elberton
M. A. Hubert, Athens
H. T. Kennedy, Warrenton
Albert G. LeRoy, Thomson
Lynn M. Huie, Monroe
J. H. Nicholson, Madison

Augusta Advisory Subcommittee

C. G. Henry, Augusta, *Chairman*
John H. Sherman, Augusta
C. M. Mulherin, Augusta
W. K. Philpot, Augusta
G. L. Kelly, Augusta

Columbus Advisory Subcommittee

Luther H. Wolff, Columbus, *Chairman*
Roy Gibson, Columbus
Peter C. Graffagnino, Columbus
Polk S. Land, Columbus
S. A. Roddenbery, Columbus

Macon Advisory Subcommittee

Willard R. Golsan, Macon, *Chairman*
Charles N. Wasden, Macon
John I. Hall, Macon
Harold C. Atkinson, Macon
Thomas L. Ross, Jr., Macon

Savannah Advisory Subcommittee

L. B. Dunn, Savannah, *Chairman*
T. A. McGoldrick, Savannah
J. C. Metts, Savannah
W. L. Osteen, Savannah
Jacob Rubin, Savannah

STATE BOARDS

State Board of Medical Examiners

(Meets in June and October)

Fred J. Coleman, Dublin—1960
Albert M. Deal, Statesboro—1959
Glenville Giddings, Atlanta, *President*—1957
R. H. McDonald, Newnan, *President-elect*—1958
Charles K. Wall, Thomasville—1959
Grady N. Coker, Canton—1960
Q. A. Mulkey, Millen—1957
J. W. Palmer, Ailey—1958
Alex B. Russell, Winder—1958
L. W. Willis, Bainbridge—1959

Medical Examiners State Board of Workmen's Compensation

Hugh Hailey, Atlanta, *Chairman*
Albert A. Rayle, Atlanta
Jack C. Norris, Atlanta
F. Kells Boland, Jr., Atlanta
Marcus Mashburn, Sr., Cumming

State Board of Health

(Meets in April and October)

R. Lee Rogers, Gainesville (9th District)—1957
J. M. Byne, Jr., Waynesboro (1st District)—1957

A. G. Funderburk, Moultrie (2nd District)—1957

Maurice F. Arnold, Hawkinsville (3rd District)—1960

Virgil B. Williams, Griffin (4th District)—1961

Harold P. McDonald, Atlanta (5th District)—1960

A. M. Phillips, Macon (6th District)—1962

Fred H. Simonton, Chickamauga (7th District), *Chairman*—1956

A. G. Little, Jr., Valdosta (8th District)—1962

D. N. Thompson, Elberton (10th District)—1961

Georgia Dental Association Representatives

J. M. Hawley, Columbus—1958
J. G. Williams, Atlanta, *Vice-Chairman*—1958

Georgia Pharmaceutical Association Representatives

J. B. Butts, Milledgeville—1959
W. W. Webb, Leslie—1959

State Medical Education Board

(Meets in June and October)

John W. Mauldin, Lawrenceville, *Chairman*—1957

J. Hubert Milford, Hartwell, *Vice-Chairman*—1957

C. L. Howard, Pelham—1957

H. Dawson Allen, Jr., Milledgeville—1957

Hal M. Davison, Atlanta—1958

Hospital Advisory Council

(Meets in April and October)

Representatives, Georgia Hospital Association

Mr. Oscar Hilliard, Ft. Oglethorpe, *Chairman*—1956
Mr. Arthur T. Stewart, Greensboro—1958
Mr. George E. Linney, Americus—1957

Representatives, Medical Association of Georgia

W. L. Pomeroy, Waycross—1959
Rafe Banks, Jr., Gainesville—1959
J. K. Quattlebaum, Savannah—1957
Joseph C. Read, Atlanta—1957
Milford B. Hatcher, Macon—1958

Representative, Georgia Dental Association

Thomas Connor, Atlanta—1957

Representative, Georgia Nursing Association

Miss Dana Hudson, Atlanta—1957

Representatives, State-at-Large

Mr. Walter Graefe, Griffin—1957
Mr. J. J. McLanahan, Elberton—1957
H. C. Derrick, Lafayette—1958

Ex-Officio Members

T. F. Sellers, Director, State Health Department
Mr. Eugene Cook, Attorney General
Mr. Alan Kemper, Director, State Welfare Department
Mr. B. E. Thrasher, State Auditor

Rehabilitation Member

Mr. A. P. Jarrell, Atlanta—1956

ANNUAL SESSION COMMITTEES

Annual Session General Chairman

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Local Arrangements Committee

Georgia Medical Society

T. A. Peterson, *Chairman*

W. Loyd Osteen, *Co-Chairman*

Entertainment

L. M. Freedman, *Chairman*

Visual Aids

David Robinson, *Chairman*

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Jules Victor, Jr., *Chairman*

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Arrangements

Peter Hydrick, College Park, *Chairman*

Meeting Room and Scientific Exhibit Arrangements

Ted F. Leigh, Atlanta, *Chairman*

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(Tentative—to be confirmed)

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Grady N. Coker, Canton

William R. Dancy, Savannah

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(Tentative—to be confirmed)

Reference Committee No. 1

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John B. O'Neal, Elberton,

Vice-Chairman

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Floyd R. Sanders, Decatur

Samuel E. Patton, Macon

Leo Smith, Waycross

Ralph Johnson, Rome

F. O. Garrison, Demorest

A. A. McNeill, Jr., Camilla

J. C. Patterson, Cuthbert

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Vice-Chairman

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William Fulmer, Savannah

Milford B. Hatcher, Macon

Frank A. Little, Atlanta

Joseph B. Mercer, Brunswick

R. C. Montgomery, Butler

H. B. Cason, Warrenton

Ralph H. Chaney, Augusta

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Vice-Chairman

James A. Green, Athens, *Secretary*

J. Frank Walker, Atlanta

A. J. Waters, Augusta

Glenn E. Seymour, Albany

George H. Boyd, Jr., Clayton

C. K. Singleton, Cairo

A. G. Leroy, Thomson

C. F. Holton, Savannah

Reference Committee No. 4

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W. L. Pomeroy, Waycross, *Secretary*

James H. Byram, Atlanta

T. A. Peterson, Savannah

Paul L. Bradley, Dalton

Charles T. Cowart, LaGrange

James W. Yeomans, Jesup

R. J. Moye, Adrian

William P. Harbin, Jr., Rome

Reference Committee No. 5

H. G. Davis, Jr., Sylvester, *Chairman*

George W. Wright, Augusta,

Vice-Chairman

Don Schmidt, Cedartown, *Secretary*

A. Hamblin Letton, Atlanta

Roy L. Gibson, Columbus

Howard C. Glover, Jr., Newnan

C. J. Roper, Jasper

C. Roy Williams, Wadley

H. E. Weems, Perry

A. M. Phillips, Macon

Reference Committee Alternates

Marcus Mashburn, Sr., Cumming

John P. Tucker, Moultrie

Harold P. McDonald, Atlanta

Alton V. Hallum, Atlanta

Cyrus W. Strickler, Jr., Atlanta

Ruskin King, Savannah

Willis P. Jordan, Columbus

Maurice F. Arnold, Hawkinsville

David R. Thomas, Jr., Augusta

Weems R. Pennington, Lincolnton

Credentials Committee

(Tentative—to be confirmed)

Eustace A. Allen, Atlanta, *Chairman*

W. W. Baxley, Macon

J. L. Elliott, Savannah

M. A. G. House of Delegates

Delegates

Alternates

Altamaha (1)

J. B. Brown, Baxley . . . '59 F. D. Kennedy, Baxley

Baldwin County (1)

W. M. Scott, Milledgeville . '58 Wallace Gibson, Milledgeville

Bartow County (1)

W. B. Quillian, Jr., Cartersville . . . '57 Lewis R. Whatley, Cartersville

Ben Hill-Irwin (1)

H. L. Dismuke, Ocilla . . '58 Francis M. Ward, Fitzgerald

Bibb County (6)

J. D. Applewhite, Macon . '57 C. L. Ridley, Jr., Macon
Samuel E. Patton, Macon . '57 Edwin R. Watson, Macon
Allan A. Cole, Macon . . '58 W. Derrell Hazlehurst, Macon
W. W. Baxley, Macon . . '58 Jule C. Neal, Jr., Macon
Milford B. Hatcher, Macon '59 Earl Lewis, Macon
E. C. McMillan, Macon . '59 Charles Boswell, Macon

Blue Ridge (1)

R. A. Burns, Blue Ridge . '59 C. C. Brooks, Blue Ridge

Bulloch-Chandler-Evans (1)

L. H. Griffin, Claxton . . '58 Helen R. Deal, Statesboro

Burke County (1)

C. G. Green, Waynesboro . '57 J. M. Byne, Jr., Waynesboro

Carroll-Douglas-Haralson (2)

Phil S. Astin, Carrollton . '58 F. M. Parks, Carrollton
C. H. Allen, Bremen . . '59 J. I. Vansant, Villa Rica

Chattahoochee (1)

M. Mashburn, Cumming . '59 D. C. Kelley, Lawrenceville

Chattooga County (1)

H. A. Goodwin, Jr., Summerville . . . '58 G. H. Little, Trion

Cherokee-Pickens (1)

C. J. Roper, Jasper . . '57 Ben K. Looper, Canton

Delegates

Alternates

Clayton-Fayette (1)

F. A. Sams, Jr., Fayetteville . . . '59 Wells Riley, Jonesboro

Cobb County (3)

M. M. Hagood, Marietta . '57 W. T. Clonts, Marietta
W. C. Mitchell, Smyrna . '58 H. D. Meadors, Marietta
E. P. Inglis, Jr., Marietta . '59 F. K. Schmidt, Marietta

Coffee County (1)

C. S. Meeks, Jr., Douglas . '59 Sage Harper, Douglas

Colquitt County (1)

John P. Tucker, Moultrie . '58 James R. Paulk, Moultrie

Coweta County (1)

H. C. Glover, Jr., Newnan . '57 John H. Thurmond, Palmetto

Decatur-Seminole (1)

C. G. Bellville, Bainbridge . '59 Edwin M. Griffin, Bainbridge

DeKalb County (3)

W. A. Mendenhall, Chamblee . . . '57 John M. Schreeder, Chamblee
Floyd Sanders, Decatur . . '58 John P. Heard, Decatur
G. L. Mitchell, Decatur . . '59 Robert I. Gibbs, Jr., Decatur

Dougherty County (2)

Charles G. Lamb, Albany . '57 Paul T. Russell, Albany
Glenn E. Seymour, Albany '58 Charles Hollis, Jr., Albany

Elbert County (1)

J. B. O'Neal, III, Elberton . '59 D. N. Thompson, Elberton

Emanuel County (1)

R. J. Moye, Adrian . . '58 H. R. Frost, Swainsboro

Flint (1)

Otha K. Coleman, Cordele . '57 Charles E. McArthur, Cordele

Floyd County (3)

Stephen D. Smith, Rome . '57 C. J. Wyatt, Rome
Ralph N. Johnson, Rome . '58 Lester J. Martens, Rome
A. V. Gafford, Rome . . '59 R. F. Corpe, Rome

<i>Delegates</i>	<i>Alternates</i>
Franklin County (1)	
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Fulton County (28)	
J. Frank Walker, Atlanta . '59	Philip Nippert, Atlanta
H. P. McDonald, Atlanta . '59	Helen Bellhouse, Atlanta
T. J. Anderson, Jr., Atlanta . '59	Lyle Herrmann, Atlanta
Alton V. Hallum, Atlanta . '59	Edward Askren, Atlanta
Samuel W. Perry, Atlanta . '59	Dan Sage, Atlanta
Henry M. Finch, Atlanta . '59	Ralph Murphy, Atlanta
Lester Rumble, Jr., Atlanta . '59	Irving Greenberg, Atlanta
Mason Lowance, Atlanta . '59	Edgar Dunstan, Atlanta
A. H. Letton, Atlanta . . '59	Lamar Peacock, Atlanta
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C. W. Strickler, Jr., Atlanta . '58	Vernon Powell, Atlanta
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Haywood N. Hill, Atlanta . '58	Napier Burson, Atlanta
Richard Wilson, Atlanta . '58	Ralph Huie, Atlanta
Amey Chappell, Atlanta . '58	Edna Porth, Atlanta
Duncan Shepard, Atlanta . '58	John McClure, Atlanta
T. N. Guffin, Atlanta . . . '58	Vernon Skiles, Atlanta
McClaren Johnson, Atlanta . '57	Hugh Hailey, Atlanta
James H. Byram, Atlanta . '57	Charles Cooper, Atlanta
J. H. Hilsman, Atlanta . . '57	Lloyd Timberlake, Atlanta
A. J. Crumbley, Atlanta . '57	Dan Burge, Atlanta
Daniel D. Hankey, Atlanta . '57	Tully T. Blalock, Atlanta
J. D. McElroy, Atlanta . . '57	David Russell, Atlanta
H. Bagley Benson, Atlanta . '57	Needham Bateman, Atlanta
L. H. Bishop, Jr., Atlanta . '57	Charles Todd, Atlanta
William C. Coles, Atlanta . '57	Edwin Evans, Atlanta
Scott Tarplee, Atlanta . . '57	Rives Chalmers, Atlanta
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W. H. Fulmer, Savannah . '57	Peter L. Scardino, Savannah
Lee Howard, Jr., Savannah . '58	Harold M. Smith, Savannah
Ruskin King, Savannah . . '58	Allen W. Coward, Savannah
T. A. Peterson, Savannah . '59	Richard L. Schley, Savannah
David Robinson, Savannah . '59	W. O. Bedingfield, Savannah
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C. A. Wilson, Jr., Brunswick . '57	J. B. Avera, Brunswick
J. B. Mercer, Brunswick . '58	Bert H. Malone, Brunswick
Gordon County (1)	
Lewis R. Lang, Calhoun . '59	W. D. Hall, Calhoun
Grady County (1)	
C. K. Singleton, Cairo . . '58	Bill M. Bailey, Cairo
Habersham County (1)	
F. O. Garrison, Demorest . '57	A. J. Walter, Sautee
Hall County (2)	
Rafe Banks, Jr., Gainesville . '59	W. P. Nicolson, III, Gainesville
P. K. Dixon, Gainesville . '58	E. L. Ward, Gainesville
Hart County (1)	
J. H. Milford, Hartwell . . '57	L. G. Cacchioli, Hartwell
Jackson-Barrow (1)	
A. B. Russell, Winder . . . '59	A. A. Rogers, Jr., Commerce
Jasper County (1)	
J. H. Pritchett, Jr., Monticello '58	M. L. Greene, Monticello
Jefferson County (1)	
C. R. Williams, Wadley . '57	W. J. Revell, Louisville
Jenkins County (1)	
A. P. Mulkey, Millen . . . '59	John R. Harrison, Millen
Lamar County (1)	
J. B. Crawford, Barnesville . '58	J. H. Jackson, Barnesville
Laurens County (1)	
W. A. Dodd, Wrightsville . '57	W. P. Roche, Jr., Dublin
Crawford W. Long (2)	
James A. Green, Athens . '58	M. A. Hubert, Athens
R. H. Randolph, Athens . '59	A. Paul Keller, Jr., Athens
McDuffie County (1)	
A. G. Leroy, Thomson . . . '59	Henry M. Althisar, Thomson
Meriwether-Harris (1)	
W. P. Kirkland, Manchester . '58	H. C. Jackson, Manchester
Mitchell County (1)	
A. A. McNeill, Jr., Camilla . '57	J. C. Brim, Pelham
Muscogee County (4)	
Roy L. Gibson, Columbus . '57	J. K. Davidson, III, Columbus
F. B. Schley, Columbus . . '57	Luther J. Roberts, Columbus
C. R. Smith, Columbus . . '58	A. B. Conger, Columbus
W. P. Jordan, Columbus . '59	Luther H. Wolff, Columbus
Newton County (1)	
H. E. Griggs, Conyers . . . '59	C. B. Palmer, Covington

<i>Delegates</i>	<i>Alternates</i>
Ocmulgee (1)	
M. F. Arnold, Hawkinsville . '58	J. D. Owens, Abbeville
Oconee Valley (1)	
C. S. Jernigan, Sparta . . . '57	C. H. Dickens, Madison
Peach Belt (1)	
H. E. Weems, Perry '59	Frank Vinson, Ft. Valley
Polk County (1)	
Don Schmidt, Cedartown . '58	R. F. Spanjer, Cedartown
Rabun County (1)	
G. H. Boyd, Jr., Clayton . '57	R. D. Evans, Clayton
Randolph-Terrell (1)	
R. B. Martin, III, Cuthbert . '59	Earl A. Mayo, Jr., Richland
Richmond County (7)	
T. W. Goodwin, Augusta . . '57	W. A. Fuller, Augusta
D. R. Thomas, Jr., Augusta . '57	W. K. Philpot, Augusta
G. W. Wright, Augusta . . . '57	C. M. Templeton, Augusta
R. C. McGahee, Augusta . . '58	Alfred M. Battey, Augusta
N. M. DeVaughn, Augusta . '58	Gordon Kelly, Augusta
A. J. Waters, Augusta . . . '59	William S. Boyd, Augusta
J. L. Chandler, Augusta . . '59	F. N. Harrison, Augusta
Screven County (1)	
G. B. Hogsette, Sylvania . '58	Katrine R. Hawkins, Sylvania
South Georgia (2)	
F. G. Eldridge, Valdosta . '57	A. G. Little, Jr., Valdosta
R. L. Stump, Jr., Valdosta . '59	Alton Johnson, Valdosta
Southeast Georgia (1)	
J. W. Palmer, Ailey '58	C. W. Findley, Vidalia
Southwest Georgia (1)	
T. W. Rentz, Colquitt . . . '57	R. B. Quattlebaum, Ft. Gaines
Spalding County (2)	
H. J. Copeland, Griffin . . . '58	A. S. Fitzhugh, Griffin
V. B. Williams, Griffin . . . '59	J. W. Landham, Jr., Griffin
Stephens County (1)	
Robert E. Shiflet, Toccoa . '57	Irving D. Hellenga, Toccoa
Sumter County (1)	
Russell Thomas, Americus . '59	R. C. Pendergrass, Americus
Taylor County (1)	
R. C. Montgomery, Butler . '58	E. C. Whatley, Reynolds
Telfair County (1)	
F. R. Mann, Sr., McRae . . '57	S. T. Parkerson, McRae
Thomas-Brooks (2)	
L. M. Shealy, Quitman . . . '59	Warren Taylor, Thomasville
F. A. Little, Atlanta '58	Park Gerdine, Quitman
Tift County (1)	
Carl S. Pittman, Sr., Tifton . '57	E. M. Flowers, Tifton
Tri-County (1)	
O. D. Middleton, Ludowici . '58	I. G. Armistead, Townsend
Troup County (2)	
C. T. Cowart, LaGrange . . . '58	E. W. Molyneaux, LaGrange
H. H. Hammett, Jr., LaGrange '59	Render Turner, LaGrange
Upson County (1)	
T. A. Sappington, Thomaston . '57	Norman Gardner, Thomaston
Walker-Catoosa-Dade (1)	
Fred H. Simonton, Chickamauga '59	Howard C. Derrick, Lafayette
Walton County (1)	
R. Wenzel, Social Circle . '58	H. B. Nunnally, Monroe
Ware County (2)	
W. L. Pomeroy, Waycross . '57	H. Ansley Seaman, Waycross
Leo Smith, Waycross . . . '59	Vilda Shuman, Waycross
Warren County (1)	
H. B. Cason, Warrenton . '58	A. W. Davis, Warrenton
Washington County (1)	
W. S. Helton, Sandersville . '57	F. T. McElreath, Jr., Tennille
Wayne County (1)	
J. W. Yeomans, Jesup . . . '59	Fred M. Harper, Jesup
Whitfield County (1)	
Paul L. Bradley, Dalton . . '58	George L. Broadrick, Dalton
Wilkes County (1)	
W. R. Pennington, Lincolnton '57	John Phinizy, Lincolnton
Worth County (1)	
H. D. Davis, Jr., Sylvester . '59	William P. Stoner, Sylvester

INFORMATION

Registration

The Official Registration Desk will be located on the Porch of the Hotel DeSoto, adjacent to the Gold Room. It will be open for the registration of Medical Association of Georgia members and guests at 12:00 noon, Sunday, April 28, 1957, and at 8:00 a.m., Monday and Tuesday, April 29 and 30. Members and guests should register there *immediately upon arrival* and obtain badges and programs.

Message Center

A message Center will be maintained (adjacent to the Registration Desk on the Porch) to receive incoming calls, and pages from the Woman's Auxilliary to the Medical Association of Georgia will staff this center during the entire session. All notices of an official nature will be posted on the Official Bulletin Board at the Message Center.

House of Delegates

The House of Delegates will meet on Sunday afternoon, April 28, at 5:00 p.m., in the Ballroom of the Hotel DeSoto and will reconvene there on Tuesday afternoon at 2:30 p.m.

Memorial Service

The Medical Association of Georgia will hold its annual Memorial Service at the opening session of the House of Delegates at 5:00 p.m., Sunday, April 28, in the Ballroom of the Hotel DeSoto, and all members are cordially invited to attend. The service is held in memory of members who died during the past year.

William Pope Baker, Atlanta, July 11, 1956
Cecil Howell Blackburn, Conyers, June 4, 1956
Leo J. Blum, Jr., Warner Robins, December 8, 1956
Charles E. Boynton, Atlanta, November 22, 1956
William Henry Brooks, Monticello, Utah, May 4, 1956
Robert Stallings Burford, Brunswick, January 2, 1957
Stevan M. Carroll, Jr., Marietta, January 24, 1957
James Mobley Combs, Atlanta, October 15, 1956
William Barron Crawford, Sr., Savannah, April 1, 1956
Frank C. Daniel, Pavo, April 12, 1956
Virgil Clyde Daves, Vienna, July 12, 1956
Howard Clifton Derrick, Sr., Oglethorpe, June 8, 1956
Roger W. Dickson, Atlanta, February 21, 1957
William Beers Dove, Macon, December 12, 1956
Charles Hall Farmer, Macon, June 23, 1956
Rupert H. Fike, Moultrie, October 29, 1956
John Funke, Atlanta, December 1, 1956
W. N. Frayser, Macon
John Lucius Garrard, Rome, December 4, 1956
Louis M. Hawkins, Blackshear, November 16, 1956

Howell Parks Holbrook, Tucker, November 13, 1956
Isaac Bell Howard, Williamson, August 10, 1956
James Nathaniel Isler, Meigs, October 25, 1956
James Swayne Jolley, Homer, December 7, 1956
Hugh M. Lokey, Atlanta, February 23, 1957
George Y. Massenburg, Sr., Macon, September 1, 1956
Roy W. McGee, Atlanta, November 29, 1956
R. M. Moore, Atlanta, January 21, 1957
C. T. Nellans, Roswell, May 25, 1956
George Tracy Olmstead, Savannah, November 29, 1956
Oscar W. Roberts, Sr., Carrollton, December 19, 1956
James Virgil Rogers, Sr., Cairo, August 25, 1956
Fletcher Adrian Smith, Elberton, July 14, 1956
Inman Parker Smith, Rome, October 5, 1956
Leighton Alexander Smith, Quitman, May 7, 1956
T. W. Stewart, Lithonia, August 13, 1956
J. T. Stovall, Jefferson, January 19, 1957
James R. Whitley, Winder, January 5, 1957
Pierce Lee Williams, Cordele, July 9, 1956

Specialty Society Luncheons and Dinners

Certain specialty societies plan to have luncheons on Sunday, Monday, and Tuesday, and dinners on Sunday and Monday during the annual session. These events are listed in the Official Program, even though they are not a part of the Official Program, so please check there for specific times and places.

Woman's Auxiliary

The Woman's Auxiliary to the Medical Association of Georgia will have its Registration Desk in the Lobby of the Hotel DeSoto. It will be open on Sunday, April 28, from 10:00 a.m. to 5:00 p.m.; Monday, April 29, from 8:30 a.m. to 3:30 p.m.; and Tuesday, April 30, from 9:00 a.m. to 12:30 p.m. The complete program giving times and locations of meetings of the 32nd Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia will be found beginning on page 129.

Social Events

Information about social events planned in conjunction with the annual session and the necessary tickets will be available at the Registration Desk, located on the Hotel DeSoto Porch. Your cooperation in purchasing your tickets at the time of registration is requested. Accomodations for social events are limited, and the sponsoring groups cannot be held responsible unless everyone cooperates in this regard.

Scientific Exhibits

Scientific Exhibits will be displayed in places set aside specifically for them in the Chatham Room

The above information is subject to change

INFORMATION

and the Pound Room of the Hotel DeSoto. These exhibits should be of great interest to members of the medical profession; they are prepared by physicians, who will be on hand to discuss their displays with you.

<i>Booth Number</i>	<i>Exhibit</i>
100	"A Pump Oxygenator"—William A. Hopkins, M. Bedford Davis, and Fernando Duraldi, Atlanta.
101	"Cardiac Cinefluorography"—J. Willis Hurst, H. Stephen Weens, James V. Rogers, Jr., Atlanta.
103	"A New Tool in the Management of Alcoholism"—Vernelle Fox, Atlanta.
104	"Dynamics of Murmurs of the Pulmonary Artery"—A. Calhoun Witham and Harold Kimmerling, Augusta.
105	"Hysterosalpingography—Gross Pathology"—Henry E. Steadman, Hapeville.
106	"The Grain of Your Skin"—W. S. Flanagan, Augusta.
107	"Cavalcade of Medicine"—Cobb County Medical Society.
108	"Carcinoma of the Thyroid: Surgical Management"—David Henry Poer, John E. Skandalakis, and Edgar O. Rand, Atlanta.
109	"Arterial Insufficiency of the Lower Extremity"—John R. Derrick, John M. Howard, Cecil M. Couves, W. D. Logan, and A. H. Wilkinson, Atlanta.
110	"Infertility: Diagnosis and Treatment"—Robert B. Greenblatt, Joan Landry, B. A., Edwin Jungck, and William E. Barfield, Augusta.
111	Georgia State Board of Health.

Commercial Exhibits

Approximately 50 Commercial Exhibits are displayed in booths on the Porch and in the Rotunda of the Hotel DeSoto. These exhibits are primarily for your education and will give up-to-date information on the latest products and services available to the profession. It is *extremely* important that you visit each of these exhibits and register with the exhibitor. Your cooperation is earnestly requested since these displays are designed and shown specifically for your benefit. The exhibitors play a very important role in making this annual session possible.

<i>Booth Number</i>	<i>Exhibitor</i>
1	Pet Milk Company, St. Louis, Mo.
2	Rhinopto Company, Dallas, Texas
3	Ross Laboratories, Columbus, Ohio
4	Ortho Pharmaceutical Corporation, Raritan, N. J.
5	E. R. Squibb & Sons, New York, N. Y.
6	Doho Chemical Corporation, New York, N. Y.
7	Desitin Chemical Company, Providence, R. I.
8	Schering Corporation, Bloomfield, N. J.
9	C. B. Fleet Company, Lynchburg, Va.
10	Warner-Chilcott Laboratories, New York, N. Y.
11	Lederle Laboratories, Division American Cyanamid Company, Pearl River, N. Y.
12	Parke, Davis and Company, Detroit, Mich.
13	Ciba Pharmaceuticals, Summit, N. J.
14	Charles C. Haskell and Company, Inc., Richmond, Va.
15	Merck Sharp and Dohme Company, Inc., Philadelphia, Pa.
16	Briston-Myers Products Division, New York, N. Y.
19	General Electric Company, X-Ray Department, Atlanta, Ga.
20	Hoffman-LaRoche, Inc., Nutley, N. J.
21	Geigy Pharmaceuticals, New York, N. Y.
22	Abbott Laboratories, North Chicago, Ill.
23	Winthrop Laboratories, Inc., New York, N. Y.
25	The William S. Merrell Company, Cincinnati, Ohio
26	Baxter Laboratories, Inc., Morton Grove, Ill.
27	William P. Poythress and Company, Inc., Richmond, Va.
28	Eaton Laboratories, Inc., Norwich, N. Y.
29	Westwood Pharmaceuticals, Buffalo, N. Y.
30	J. B. Roerig and Company, Chicago, Ill.
31	U. S. Vitamin Corporation, New York, N. Y.
32	A. S. Aloe Company, Chamblee, Ga.
33	A. H. Robins Company, Inc., Richmond, Va.
34	Lloyd Brothers, Inc., Cincinnati, Ohio
35	Hart Drug Company, Miami, Fla.

— be sure to check with the Official Program

INFORMATION

<i>Booth Number</i>	<i>Exhibitor</i>
36	Julius Schmid, Inc., New York, N. Y.
37	Donley-Evans and Company, St. Louis, Mo.
38	Medco Products Company, Tulsa, Okla.
39	Wyeth Laboratories, Philadelphia, Pa.
40	Kremers-Urban Company, Milwaukee, Wis.
41	Van Pelt and Brown, Inc., Richmond, Va.
42-43	Wachtel's Physician Supply Company, Savannah, Ga.
44	deLeon Laboratories, Atlanta, Ga.
45	Coca-Cola Company, Atlanta, Ga.
46	Eli Lilly and Company, Indianapolis, Ind.
47	American Ferment Company, Inc., New York, N. Y.
48	Charles Pfizer and Company, Brooklyn, N. Y.
49	J. B. Lippincott Company, Philadelphia, Pa.
50	Holland Rantos Company, Inc., New York, N. Y.
51	G. D. Searle and Company, Chicago, Ill.

Fifty Year Members

The following list contains the names of all the members of the Medical Association of Georgia who, as of this year 1957, have practiced medicine

for 50 years. It does not record the names of physicians who have already received gold membership cards; this is the class of 1957 only.

George Bachmann	Atlanta
George T. Banks	Fairmont
Guy T. Bernard	Augusta
Montague L. Boyd	Atlanta
Daniel M. Bradley	Waycross
Robert F. Cary	Macon
Virgil C. Cooke	Savannah
William S. Cook	Albany
Frank L. Eskridge	Atlanta
John L. Garrard	Rome
C. C. Giddens	Valdosta
Ernest R. Harris	Winder
Edward M. McDonald	Winder
C. G. Redmond	Savannah
Clarence A. Rhodes	Atlanta
Harry Y. Righton	Savannah
Henry L. Sams	Dalton
Clyde A. Stevenson	Camilla
Julius C. Stone	Doerun
Thomas J. Vansant	Woodstock
Orlando S. Wood	Washington

OFFICIAL CALL

TO THE OFFICERS AND MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA:

The *103rd Annual Session of the Medical Association of Georgia will be held in Savannah, Georgia, April 28-May 1, 1957.

The official registration desk, located on the porch of the Hotel DeSoto, will be opened for registration of MAG members and guests at 12:00 noon, Sunday, April 28, and at 8:00 a.m., Monday and Tuesday, April 29 and 30. The desk will close at the end of the last meeting of each day.

The House of Delegates will convene at 5:00 p.m. on Sunday, April 28, in the Ballroom of the Hotel DeSoto.

The scientific sessions of the Association will open Sunday, April 28, with specialty section programs beginning at 1:15 p.m. Monday morning will be devoted primarily to general practitioners with a general session beginning at 8:15 a.m. The general session will be reconvened at 8:15 p.m. Monday for an evening panel discussion. The specialty sections will meet on Sunday, Monday, and Tuesday, April 28, 29, and 30, 1957, as follows:

Sunday, April 28

Neurology, Neurosurgery, and Psychiatry Section
Pediatrics, Orthopedics, and Radiology Joint Section
Surgery, E.E.N.T., and Anesthesiology Joint Section

Monday, April 29

Obstetrics and Gynecology and General Practice
Joint Section
Anesthesiology Section
Diabetes and Medicine Joint Section
Radiology Section
Surgery and Pathology Joint Section
Urology Section

Tuesday, April 30

Surgery and Industrial Surgery Joint Section
Diabetes, Chest, and Medicine Joint Section

The president and other new officers will be installed at the MAG General Business Session, 10:30 a.m., Wednesday, May 1, 1957.

HAL M. DAVISON, *President*

DAVID HENRY POER, *Secretary-Treasurer*



president's letter

SOMEONE ASKED: "Why do doctors go to medical meetings? Why not stay at home and read the papers in the *Journal*?" The answer is clear and definite. It is a stimulating and an educational experience to read a paper before one's brother physicians and have them tear it to pieces with their criticism or give it their approval. It is just as stimulating and educational to listen to the papers and to take part in the criticism or in the approval. Then comes private discussion about ideas in medicine and about interesting and puzzling cases which is just as helpful and just as stimulating as hearing papers. Check the program of our annual session. It has something interesting and educational for every doctor in our state. Your Program Committee has procured speakers who are pre-eminent in our profession and authorities on their subjects. In addition we will have other subjects of interest discussed by our own members who are just as worthy of your attention.

Another reason for coming to our annual meeting is to renew our fellowship with old friends and, with them, to get a little recreation. In addition to seeing

old friends, we always make new ones. Savannah is a wonderful place for a vacation and is renowned for its wonderful hospitality and entertainment.

Every member of our state association needs to be informed about the activities of his society. Never before has it been involved in so much activity in trying to settle so many important questions. You have been informed about these matters by reports in your *Journal* from time to time, but the annual meeting will bring you up-to-date and give you an opportunity to take a personal part in what is going on.

For medicine to continue to progress we doctors need organization. We need at this meeting every doctor in the state who can be spared from practice. We need his interest and his active support in settling our problems.

So, there are many reasons why we doctors go to medical meetings. All of them are good ones. Make your plans to be present in Savannah. It is a good place to be for any reason.

Hal M. W. Anison.

Guest Speakers

Stewart H. Clifford, M.D.

Brookline, Mass.

Sponsored by
Georgia Pediatric
Society



STEWART H. CLIFFORD, M.D., of Brookline, Mass., will address the Pediatrics, Orthopedics, and Radiology Joint Section on Sunday, April 28th, at 2:00 p.m., on "Respiratory Problems of the Newborn, Including the Hyalin Membrane Syndrome." In the same meeting, Dr. Clifford will be one of the panelists discussing

"Modern Everyday Concepts of Scurvy and Rickets." Dr. Clifford will also address the G. P. Day General Session on Monday at 9:45 a.m. His subject will be "Perinatal Mortality and Morbidity in Postmaturity with Emphasis on Obstetrical Management."

This well known pediatrician graduated from Harvard Medical School and interned in internal medicine at Massachusetts General Hospital. He took training in contagious diseases at Willard Parker Hospital and pediatric training at the Children's Hospital of Boston. He is at present Assistant Clinical Professor of Pediatrics at Harvard Medical School, pediatrician to the Boston Lying-In Hospital, and Chief of the Newborn Service at the Children's Medical Center.

He is a member of the New England Pediatric Society; American Pediatric Society, of which he is editor and recorder; the Society for Pediatric Research; and he is a fellow of the American Academy of Pediatrics. He is on the editorial board of the *Journal of Pediatrics* and is Vice-president (president-elect) of the American Academy of Pediatrics.

Robert J. Coffey, M.D.

Washington, D.C.

Sponsored by
Georgia Chapter,
American College
of Surgeons



ROBERT J. COFFEY, M.D., of Washington, D. C., Professor of Surgery and Director of the Department of Surgery of Georgetown Medical Center, will address the session four times on various surgical topics.

Dr. Coffey is a native of Elmira, N. Y., and received his education at St. Bonaventure College and Georgetown University Medical School; he was awarded the M.S. in medicine and Ph. D. in surgery by the University of Minnesota. Dr. Coffey served in the U. S. Navy from 1942 through January 1946 and is at present National Consultant in Surgery to the Surgeon General of the United States Air Force.

Dr. Coffey is a member of the American College of Surgeons, Southern Medical Association, Southern Surgical Association, Southeastern Surgical Congress, Surgeons Travel Club, International Society of Surgery, Association of Military Surgeons of the U. S., and the American Surgical Association.

The first paper to be delivered will be presented before the Surgery, E.E.N.T., and Anesthesia Joint Section on Sunday, April 28th. The title of his talk is "Hazards of Steroid Therapy in the Surgical Patient." A summary follows:

The increasing use of steroids poses a serious problem to the surgeon. This is a two-fold problem, namely: (1)

in the patient in whom previous steroid therapy has been employed for other reasons and in whom the treatment has been either discontinued or diminished; and (2) in the patient in whom steroid therapy is employed as an adjunct to operative treatment. A comprehensive review of all surgical patients in whom steroids have been employed and the complications resulting therefrom will be presented.

On Monday, April 29th, Dr. Coffey will present to the G. P. Day General Session "Recommendations to the G. P. Doing General Surgery."

It is with an awareness that the majority of operative procedures throughout the country are carried out by general practitioners that recommendations of a general character are made concerning the approach to a variety of surgical problems that are encountered by the general practitioner. Problems in both diagnosis and treatment of surgical conditions of the gastrointestinal tract, the biliary-pancreatic systems, endocrine glands, the area of the acute abdomen, and in trauma will be discussed.

Also on Monday, Dr. Coffey will address the Surgery and Pathology Joint Section. A precis of his paper on "The Relation of Polyps to Cancer of the Colon" follows:

The polyp-cancer sequence in the colon is emphasized with a presentation of pathologic and surgical evidence to support this relationship. A survey of experiences relating to the diagnosis and treatment of both multiple and single polyps with and without an associated malignant change will be presented.

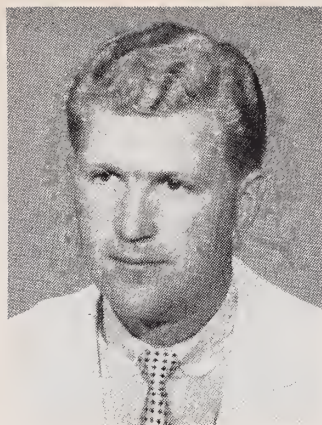
His fourth and last presentation will be before the Surgery and Industrial Surgery Joint Section on Tuesday, April 30th. His subject will be "Surgical Treatment of Duodenal Ulcer." The summary follows:

As a result of a distressingly high incidence of the "dumping syndrome" and nutritional disability following the conventional high gastric resection and gastrojejunostomy in the treatment of duodenal ulcer, a combined procedure of vagotomy, hemigastrectomy and end-to-side gastroduodenostomy has been attempted as the routine surgical treatment of duodenal ulcer. A survey of experimental studies carried out to assess the relative effectiveness of this procedure plus a presentation of clinical results over a five-year period will be presented.

**Irving S.
Cooper, M.D.**

New York, N. Y.

*Sponsored by
Georgia Psychiatric
Association*



IRVING S. COOPER, M.D., Ph.D., of New York, N. Y., will speak to the Neurology, Neurosurgery, and Psychiatry Section at 2:15, Sunday afternoon, on "Chemopallidectomy: The Effects of this Operation upon Tremor, Rigidity, and other Extrapyramidal Movement Disorders."

The operation of chemopallidectomy, the gradual destruction of the mesial globus pallidus by neurolytic agents through an in-lying polyethylene catheter, has now been employed in a series of more than 300 operations. It will be the purpose of this report to summarize

the results which have been obtained in this series of cases and to evaluate the clinical and physiologic implications of these results. It is hoped to elucidate the present status of chemopallidectomy in the treatment of extrapyramidal disorders. It is also the purpose of this communication to contribute to an understanding of the role of globus pallidus and the mechanism of tremor, rigidity, chorea, athetosis, and dystonia. Although the globus pallidus apparently does not determine the patterns or configuration of any of these hyperkinetic manifestations, there is evidence to suggest that it contributes, in part, to the mechanism of each.

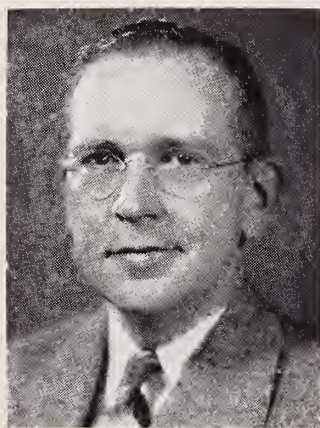
Dr. Cooper is a graduate of George Washington University and George Washington University Medical School. He interned at the U. S. Naval Hospital and served as a lieutenant, junior grade, in the Naval Reserve from 1946 through 1948. He was a fellow in neurosurgery at the Mayo Foundation, 1948-1951, and is now Assistant Professor of Neurosurgery at New York University—Bellevue Medical Center and Director of the Department of Neurologic Surgery at St. Barnabas Hospital in New York City.

Dr. Cooper is a member of the Harvey Cushing Neurosurgical Society, the Neurosurgical Society of America, American Academy of Neurology, American Federation for Clinical Research, and Sigma Xi Society.

**Ormond S.
Culp, M.D.**

Rochester, Minn.

*Sponsored by
Georgia Urological
Association*



ORMOND S. CULP, M.D., Rochester, Minn., will address the Urology Section on Monday, April 29th, on "Hypospadias". A resumé of his paper is presented below:

Many diversified problems were encountered in the treatment of congenital chordee and hypospadias during the past six years. In addition to all degrees of classical untreated deformities, this series includes patients who required operations because of (a) hypospadias without chordee, (b) chordee without hypospadias, and (c) a

variety of postoperative complications. More than 100 patients have been cured. Many therapeutic plans had to be employed. Advantages and disadvantages of operations now in vogue have become apparent. Some unfortunate sequelae seem to be inevitable and must be dealt with realistically, but experience has shown that most complications can be avoided.

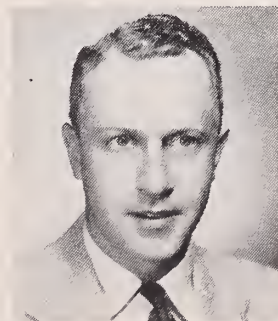
Dr. Culp is a native of Toronto, Ohio, and was educated at Ohio Wesleyan University and Johns Hopkins University, where he received his M.D. degree in 1935. He received his training in urology at Johns Hopkins Hospital and Ancker Hospital, St. Paul, Minn. He was Instructor in Urology at Johns Hopkins University, 1938-1942; served in the U. S. Army Medical Corps, 1942-1946; and was Urologic Consultant, Veterans Administration, 1946-1952; Associate Surgeon-in-charge, Henry Ford Hospital, Detroit, Mich., 1946-1950; and has been Consultant in Urology, Mayo Clinic, Rochester, Minn., since 1950.

Dr. Culp is a member of the North Central Section of the American Urological Association, American Urological Association, American Association of Genito-Urinary Surgeons, International Society of Urology, and the Urologic Forum for Clinical Investigation, among other organizations.

**David A.
Davis, M.D.**

Chapel Hill, N. C.

*Sponsored by
Georgia Society of
Anesthesiologists*



DAVID A. DAVIS, M.D., Chapel Hill, N. C., will address the Anesthesiology Section on Monday, April

29th, on "Some Clinical Experience with Fluothane—A New Non-flammable Anesthetic".

Dr. Davis is a graduate of Vanderbilt University School of Medicine and a former Instructor in Surgery and staff physician at the Ochsner Clinic in New Orleans and Associate Professor of Anesthesiology at the Medical College of Georgia in Augusta. He is at present Professor of Anesthesiology at the University of North Carolina School of Medicine.

A summary of Dr. Davis' paper follows:

For several years it has been recognized that certain compounds containing fluorine possess anesthetic properties. Likewise, the substitution of halogens in hydrocar-

bons reduces their flammability. One of these compounds under clinical investigation is trifluor-chlor-brom ethane, or Fluothane. This is a very potent inhalation anesthetic

agent which shows considerable promise, particularly in areas where the use of a non-explosive agent is dangerous.

**Donald B.
Effler, M.D.**

Cleveland O.

*Sponsored by
Georgia Chapter,
American College of
Chest Physicians and
Georgia Trudeau Society*



DONALD B. EFFLER, M.D., Cleveland, Ohio, will address the Diabetes and Medicine Joint Section on Monday, April 29th, on "Lung and Pericardial Biopsy", which is summarized here:

Widespread use of the routine chest film has uncovered many unsuspected disease entities. The most important of these is the diffuse pulmonary process, the so-called "medical chest problem." When all of the established routine studies have been performed and the diagnosis is still not established, some form of surgical biopsy is indicated. The limitations of the scalene node biopsy will be discussed, and the indications for direct lung biopsy through a simple thoracotomy approach will be presented. Clinical experience over an eight year period will also be presented.

Diseases of the pericardium that present as recurrent pericarditis, with or without effusion, may also present problems of diagnosis and therapy. A technique of surgical pericardial biopsy to provide material for culture and histopathologic study will be presented and its indications discussed. Application of this technique in the treatment of chronic pericardial effusion will also be presented in diagrammatic form.

Dr. Effler will also speak to the Diabetes, Chest, and

Medicine Joint Section which meets on Tuesday, April 30th. His subject, "Elective Cardiac Arrest" is summarized below:

With the development of the cross-circulation principle, cardiac surgery is now performed with the conventional heart by-pass employing some form of pump oxygenator. The conventional by-pass excludes the systemic return of blood through both cavae and diverts it to the pump oxygenator where it is returned in a saturated state to the aortic arch usually via a subclavian artery. This technique, however, does not provide a dry heart or a motionless field for the surgical procedure. The coronary return to the right atrium provides an appreciable blood return to the by-passed heart and in itself may represent a sizable blood loss. The disadvantages of cardiac motion are obvious.

Elective cardiac arrest is the most significant adjunct since the development of the cross-circulation technique. A brief description of technique will be presented. Elective cardiac arrest employing potassium citrate in a blood mixture is a simple, safe procedure that offers the surgeon a dry, motionless field in most cases. Clinical experience in about 85 cases will be presented.

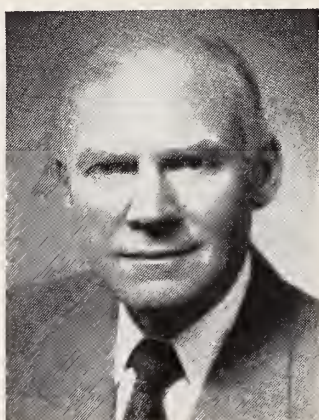
Dr. Effler received his B.A. and M.D. degrees from the University of Michigan, the latter in 1941. He had postgraduate training at Walter Reed Army Hospital, Gallinger Municipal Hospital, George Washington University Medical School, Washington; The Hospital of the Good Samaritan and Children's Hospital, Los Angeles, and The Cleveland Clinic Foundation, Cleveland, Ohio. He is at present Chief of the Department of Thoracic Surgery at the Cleveland Clinic Foundation and Associate Professor of Thoracic Surgery at the Frank E. Bunts Institute in Cleveland.

He is a member of the American Association of Thoracic Surgery, the American College of Surgeons, American Trudeau Society, Central Surgical Association, and the Society for Vascular Surgery, in addition to local and state associations.

**Albert C.
Furstenberg, M.D.**

Ann Arbor, Mich.

*Sponsored by
Equen Memorial
Lecture*



A. C. FURSTENBERG, M.D., Ann Arbor, Mich., will speak on Sunday to the Surgery, E.E.N.T., and Anesthesiology Joint Section on "Tumors and Cysts of the Head and Neck."

There is, perhaps, no chapter in the study of pathology more interesting than that which treats of the tumors and cysts of teratological origin. The occurrence of these lesions in various organs of the body as the result of congenital disturbances of development or the misplacement of embryonal cells, is a common example of

a few of the mysterious factors pertaining to the genesis of neoplastic growth. In one instance we may be dealing with a tumor which develops from a mass of tissue misplaced during the development of the embryo, in another, the neoplasm is more logically explained as a proliferation of aberrant cell collections. Both formations give rise to an extensive group of heterologous tumors, varying from the simple cysts to the larger, more complex teratoid growths which may contain a collection of widely differentiated cells from many organs of the body.

Dr. Furstenberg is a graduate of the University of Michigan Medical School, class of 1915, where he is presently Professor of Otolaryngology and Dean of the Medical School. Dr. Furstenberg is a native of Saginaw, Mich., and has been on the faculty of The University of Michigan Medical School since 1918 when he was appointed Instructor in Otolaryngology.

Dr. Furstenberg served as a first lieutenant in the medical corps during the First World War and is a consultant to the Surgeon General of the U. S. Army. He is an honorary consultant to the Army Medical Library, a fellow of the American College of Surgeons, of which he was second vice-president and member of the board of governors, 1943-46; a member of the

American Board of Otolaryngology; member of the American Academy of Ophthalmology and Otolaryngology, Detroit Otolological Society, American Laryngological, Rhinological, and Otological Society (president, 1946), American Otological Society (president 1952-

53), American Laryngological Society, and the Association of American Medical Colleges (past president). Aside from his medical activities, he is Director of the Ann Arbor (Mich.) Trust Company and of the Ann Arbor Bank.

**Clifford F.
Gastineau, M.D.**

Rochester, Minn.

Sponsored by
Georgia Diabetes
Association



CLIFFORD F. GASTINEAU, M.D., Rochester, Minn., will speak before the Diabetes and Medicine Joint Section on "Diabetic Acidosis." Dr. Gastineau's talk will be presented at 3:20 on Monday, April 29th. In summarizing his paper, Dr. Gastineau has this to say:

Diabetic acidosis is a most complex problem. It involves disturbances of numerous metabolic processes. There are deficits of water and a number of electrolytes, and the metabolism of carbohydrates, fats, and proteins is grossly distorted. No two patients exhibit identical changes, and the treatment should be adapted to the problem at hand. In many instances, complications such as myocardial infarction or infection may add to the difficulty of treatment.

A systematic record of the physical findings, laboratory data, and treatment administered is essential. If such information is clearly charted, the planning of treatment is greatly facilitated.

Insulin deficiency is the primary cause of diabetic acidosis, and administration of adequate amounts of insulin is the most urgent and important part of therapy. The amounts of insulin given should be determined by estimates of the seriousness of the acidotic process as a whole and not by the blood sugar alone. Solutions of sodium, chloride, potassium, phosphate, fructose, and glucose are given parenterally in different phases of treatment. The amounts and time of administration of such solutions will depend upon such factors as rate of urinary flow, degree of dehydration, and laboratory data.

On Tuesday, April 3th, Dr. Gastineau will participate in a panel on the "Management of Medical Emergencies" in the Diabetes, Chest, and Medicine Joint Section Meeting.

Dr. Gastineau is a graduate of the University of Oklahoma School of Medicine, class of 1943; he interned at the University of Colorado Hospital and was a fellow in the Mayo Foundation from 1944 to 1949, and since 1950 has been a member of the staff of the Mayo Clinic. He is Assistant Professor of Medicine, University of Minnesota Graduate School, and a diplomate of the American Board of Internal Medicine. He served with the U. S. Army Medical Corps from 1953 to 1955.

**John R.
Hodgson, M.D.**

Rochester, Minn.

Sponsored by
Georgia Radiological
Society



JOHN R. HODGSON, M.D., Rochester, Minn., was born in Muskegan Heights, Mich. He attended the University of Michigan and received his M.D. degree there in 1940. After internship and residency at Providence Hospital, Detroit, he went to the Mayo Clinic in 1943, as a fellow. He was appointed to the staff as Consultant in Radiology in 1947. He has been successively Instructor and Assistant Professor in the Mayo Foundation Graduate School of the University of Minnesota. He received the M.S. degree in radiology from the University of Minnesota in 1946.

On Sunday, April 28th, Dr. Hodgson will address the Pediatrics, Orthopedics, and Radiology Joint Section on "Roentgenological Aspects of the Differential Diagnosis of Sclerosing Lesions of Bone in Infants and Children."

This presentation will deal with the differential diagnosis of sclerotic lesions of bone in infants and children. In many instances, the differential diagnosis can be extremely difficult for the roentgenologist without some clinical information. This will be a presentation of cases causing sclerotic lesions in bone with special reference to those in which roentgenologic diagnosis may be a problem.

On Monday, April 29th, he will address the G. P. Day General Session on "Roentgenological Aspects of Bleeding Lesions of the Gastrointestinal Tract in Infants and Children." A summary of the paper follows:

Bleeding from the alimentary tract is an important manifestation of significant disease in all age groups but particularly so in infants and children. Although the astute pediatrician often is able to suggest accurately the source of the blood as a result of careful evaluation of history and physical findings, the roentgen examination is of great value in providing information concerning the exact location and appearance of any lesion. The roentgenologist, therefore, is directly concerned with the causes of gastrointestinal bleeding in infants and children and the relative frequency of lesions producing it.

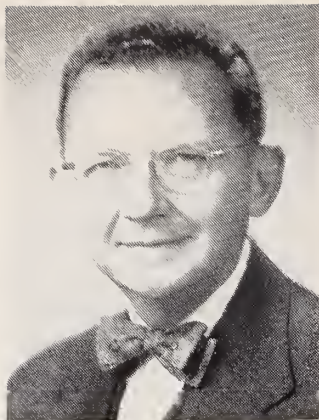
On Monday, April 29th, at 2:30, he will address the Radiology Section on "Cholecystography and Cholangiography," which is summarized below.

In recent years many new elements have been introduced in the field of cholecystography. New contrast media, new positions for cholecystography, and new procedures have been suggested and in many cases adopted. Have these changes improved the accuracy of cholecystography? Enough experience has accumulated regarding cholangiography with cholografin to properly evaluate this procedure as a diagnostic tool.

**Chester S.
Keefer, M.D.**

Boston, Mass.

*Sponsored by
Abner Wellborn
Calhoun Memorial
Lectureship*



CHESTER S. KEEFER, Boston, Mass., will be the Abner Wellborn Calhoun Memorial Lectureship speaker at noon on Tuesday, April 30th. His topic will be "Thrombosis and Thrombophlebitis." The lecture will be concerned with some of the basic problems concerning thrombosis, thrombophlebitis, and phlebothrombosis. It is widely recognized that one of the major problems today in clinical medicine is spontaneous intravascular clotting of blood in arteries, capillaries, and

veins. A brief summary of our present day knowledge of thrombosis will be given, and the problems for the future will be pointed out. Methods of treatment will be presented and discussed.

Dr. Keefer graduated from Johns Hopkins University Medical School and has been a member of the medical faculties of Johns Hopkins University, the University of Chicago, Peiping Union Medical College, and Harvard Medical School. Since 1940, Dr. Keefer has been Professor of Medicine at Boston University, and Physician-in-chief and Director of the Department of Clinical Research and Preventive Medicine of the Massachusetts Memorial Hospitals.

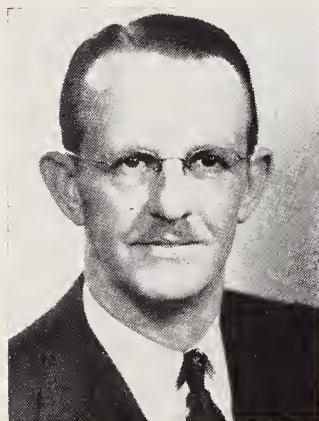
During World War II, Dr. Keefer was medical administrative officer of the Committee on Medical Research of the Office of Scientific Research and Development, and more recently he served for two years as Special Assistant for Health and Medical Affairs in the Department of Health, Education, and Welfare in Washington, D. C.

His main interests have been in clinical investigation and internal medicine, with special emphasis on infectious diseases.

**Southgate
Leigh, Jr., M.D.**

Norfolk, Va.

*Sponsored by
Georgia Industrial
Surgeons' Association*



SOUTHGATE LEIGH, JR., Norfolk, Va. will address the Surgery and Industrial Surgery Joint Section on Tuesday, April 30th at 11:00 o'clock. His topic will be "Hand Injuries—Fundamental Principles of Conservative Treatment." A summary follows:

It is easy to amputate fingers, a thumb, or a portion of the hand; it is much more difficult to save them. The loss of even the distal phalanx of a finger greatly incapacitates the worker in modern industry because so much of the trained hand is concentrated in the finger tips. We must save them wherever possible.

The principles of conservatism will be demonstrated with diagrams. A newer principle, using thin strips of adhesive instead of sutures, will be applied to the commoner injuries of the fingers, thumb and hand, combined with removable wire sutures in tendons and ligaments and Kirshner wires in bones.

When a hand is injured, it should not be amputated at the level of undamaged tissue; it should be treated conservatively with the restoration of its function to as near normal as possible. A finger partially ankylosed in a good position of function is more useful than no finger at all.

Dr. Leigh is a graduate of the University of Virginia and the Medical College of the University of Virginia. He is a member of the Medical and Surgical Section of the Association of American Railroads, a fellow of the Southeastern Surgical Congress, past vice-president of the American Association of Railway Surgeons, past president of the Seaboard Medical Society of Virginia and North Carolina, and past president of Pennsylvania Railroad Surgeons Association. He is Chief Surgeon of the Seaboard Air Line Railroad Company; Division Surgeon of the Virginian Railroad; Chief Surgeon, Norfolk Area, Norfolk and Western Railway; Local Surgeon of the Chesapeake and Ohio Railway Company, and Local Surgeon of the Pennsylvania Railroad.

**Paul V.
Lemkau, M.D.**

New York, N. Y.

*Sponsored by
Georgia Psychiatric
Association and
Georgia Department
of Public Health*



PAUL V. LEMKAU, M.D. New York, N. Y., will speak on Sunday, April 28th, to the Neurology, Neurosurgery, and Psychiatry Section. His topic will be "Community Mental Health Development," and his talk is summarized below:

Up until the beginning of the present century, there has been a trend away from local responsibilities for handling mental health problems toward concentrating responsibility at the state level. With the development of the concepts of psychological stress as one of the possible causes of mental illnesses, there arose in the state hospitals a dissatisfaction with their isolation from the communities where these stresses played upon the individual; they felt isolated from the causative factors in the illnesses they were treating. As a response to this, they began to build out-patient services. In many cases

the hospitals, however, were too large to serve the populations furnishing their patients. Dissatisfactions arose with this system, and there is now a perceptible trend to return responsibilities to local government at least for short-term treatment, whether in or out of hospitals.

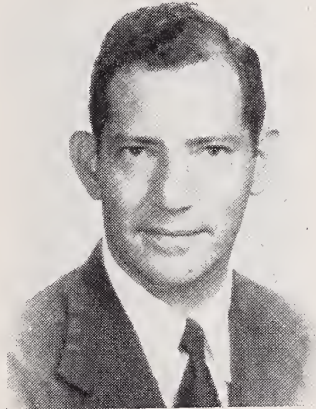
Contributing factors were also the military psychiatry which discovered that cases are best treated "within the sound of the guns" and the rising public interest in the prevention and treatment of the mental illnesses.

Dr. Lemkau, who is the Director of Mental Health Services of the New York City Community Health Board, is a native of Springfield, Illinois. He received his

Frank R. Lock, M.D.

Winston-Salem, N. C.

**Sponsored by
Georgia State
Obstetrical and
Gynecological
Society**



FRANK R. LOCK, M.D., Winston-Salem, N. C., Professor of Obstetrics and Gynecology of Bowman Gray School of Medicine of Wake Forest College, and Director of Obstetrics and Gynecology, North Carolina Baptist Hospital, Winston-Salem, will address the G. P. Day General Session at 9:15, Monday, April 29th. His topic will be "Office Gynecology," a summary follows:

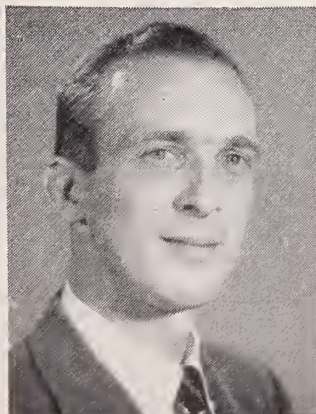
Gynecology is a major field of medical practice, and the vast majority of gynecologic problems are suitable for medical management on an out-patient basis. These complaints comprise a considerable segment of the office practice of all physicians, and a few of them are rather trying to the patient and physician.

This presentation will review the common gynecologic problems and techniques of management presently employed in the Out-patient Department of the Bowman Gray School of Medicine of Wake Forest College.

James W. Murray, LL.B.

Atlanta, Ga.

**Sponsored by
Georgia Academy
of General Practice**



JAMES W. MURRAY, LL.B., Regional Representative of the Bureau of Old-Age and Survivors Insurance, De-

A.B. degree from Baldwin-Wallace College in 1931 and his M.D. degree from Johns Hopkins University Medical School in 1935. His postgraduate training includes rotating internship at the Hospital for the Women of Maryland, Baltimore; internship and residency in psychiatry at Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore. He was Professor of Public Health Administration (Mental Hygiene) at the School of Hygiene and Public Health, Johns Hopkins University, from January 1941 to 1955, with leave from July 1941 to 1946 for service with the U. S. Army Medical Corps.

On Monday, Dr. Lock will address the Obstetrics and Gynecology and General Practice Joint Section on "Problems in Maternal Mortality" and will be a panelist for a discussion of "Maternal Deaths in Georgia During 1956." A summary of his presentation on "Problems in Maternal Mortality" follows:

The Maternal Welfare Committee of the Medical Society of the State of North Carolina has conducted a maternal mortality survey since August 1, 1946. Each maternal death is reviewed by the committee to learn the exact cause of death and preventable factors by which it might have been avoided. Although common obstetric problems such as toxemia of pregnancy and obstetric hemorrhage continue to be the principal cause of maternal morbidity and mortality, much can be learned from the changing trends in modern obstetric practice.

This paper is a review of the recent experience with major obstetric complications in the State of North Carolina, and the common preventable factors will be presented.

Dr. Lock is a graduate of Cornell University and the Tulane University School of Medicine. He is a member of the American Gynecologic Society, the American Association of Obstetricians and Gynecologists (Secretary 1953-56), the American Board of Obstetrics and Gynecology (Associate Examiner), American College of Obstetricians and Gynecologists (Chairman, District IV), American College of Surgeons (Board of Governors, representing American Gynecologic Society 1956-59), and the South Atlantic Association of Obstetricians and Gynecologists.

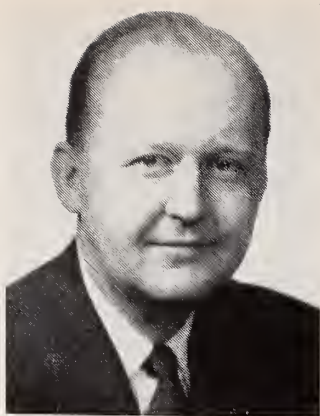
partment of Health, Education, and Welfare, Atlanta, will participate in the program scheduled for Monday Evening, April 29th, on "Social Security and the Physician". Mr. Murray will present an explanation of the whys of old-age, survivors, and disability insurance; present and future costs; eligibility requirements; and benefits payable.

We can think of no one in this part of the country who is better qualified to make this explanation. Mr. Murray, a native South Carolinian, is a graduate of The Citadel, the Military College of South Carolina; and he received the LL.B. degree from Georgetown University. He was with the Social Security Administration in Washington, D. C., for seven years, and has been O. A. S. I. Regional Representative (six Southeastern States) since his return from military service in March 1946.

**C. Joseph
Stetler, LL.B.**

Chicago, Ill.

*Sponsored by
Georgia Academy
of General Practice*



C. JOSEPH STETLER, LL.B., LL.M., Director of the Law Department of the American Medical Association, Chicago, is the other discussor of "Social Security and the Physician" at the G. P. Day General Session (re-convened) Monday Evening, April 29th at 8:30.

Mr. Stetler was formerly Secretary to the Council on National Emergency Medical Service and Secretary to the Committee on Legislation of the A. M. A. He was born in Ohio and spent most of his early life in Fort Wayne, Indiana. He went to Washington, D. C., in 1935 to work with the Civil Service Commission and has also worked with the Social Security Administration, Veterans Administration, and the War Claims Commission as Director of the Legislation and Opinions

Service. Mr. Stetler received his law degree from Catholic University in Washington, D. C., and is a member of the Chicago Bar Association, Illinois Bar Association and American Bar Association.

A summary of Mr. Stetler's presentation follows:

The number and types of bills considered during the 84th Congress dealing with Social Security in general and its effect upon the medical profession in particular has greatly increased the amount of interest that doctors have in this subject.

Although self-employed, practicing physicians are specifically excluded from Old-Age and Survivors Insurance coverage under the Social Security Act, there are a number of provisions of the law which concern the physician, as an employer, as an employee, as a self-employed business man, and in his professional capacity. Thus it is important that doctors have at least a general knowledge of the subject.

In addition, it is imperative that the medical profession remain alert to the changes and amendments to the Social Security program that are continually being proposed. Among these proposed changes are the extension of coverage to include physicians and the provision of monthly cash benefits based upon permanent and total disability. The history of the efforts to amend the law during the 84th Congress to provide disability benefits and the work of the medical profession and others in combatting this move provides an interesting story.

The pattern of Social Security in this country since its inception in 1935 indicates clearly that further expansions of the program are in the planning stage. Many of these proposed changes will, if enacted, have a profound effect upon medical practice in this country.

**Harvey
Nelson, M.D.**

Minneapolis, Minn.

*Sponsored by
Georgia Industrial
Surgeons' Association*



HARVEY NELSON, M.D., Minneapolis, Minnesota,

will address the Surgery and Industrial Surgery Joint Section on "Back Injuries" at 9:00 a.m. on Tuesday, April 30th. A summary of his paper is presented below:

A brief review of the anatomy of the vertebrae and intervertebral discs will be correlated with a graphic description of the mechanics of movement in the various segments of the spine. The manner in which disruption of this anatomy, by compression fractures, lends itself to conservative management will be discussed. The reasons for and a description of functional treatment will be given as well as the results of experience with it over a seven year period.

Dr. Nelson is chief surgeon of the Soo Line Railroad. He is a graduate of the University of Minnesota Medical School, class of 1925. He is a fellow of the American College and Surgeons and a member of the Industrial Medical Association.

**William B.
Rawls, M.D.**

New York, N. Y.

*Sponsored by
Georgia Academy
of General Practice*



WILLIAM B. RAWLS, M.D., New York, N. Y., will address the G. P. Day General Session on "The Differential Diagnosis and Office Management of the Pa-

tient with Rheumatoid Arthritis."

A brief history of the frequency of rheumatoid arthritis, the differential diagnosis, and prognosis from a practical standpoint will be given. A short period will be devoted to the general management of the patient—aside from the rheumatic symptoms. Then the various forms of therapy, exactly as it is applied in the office, will be discussed. This will include gold salts, cortisone, including all the new preparations, phenylbutazone, physical therapy, exercise, rest, anticoagulants with cortisone, and the intra-articular injections of hydrocortisone. Results with each type of therapy will be given.

Dr. Rawls is a native of Georgia and a graduate of Mercer University and Emory University School of Medicine. He received postgraduate training at Grady Memorial Hospital in Atlanta, Shreveport (La.) Charity Hospital, St. Luke's in Ohio, Memorial Hospital, Richmond, and New York Polyclinic Hospital.

Dr. Rawls is a past-president of New York County

Medical Society and past-president of the New York Rheumatism Association; he is attending physician, New York Polyclinic Hospital and St. Clair Hospital, and Chief of the Arthritis Clinic at Polyclinic Hospital.

He is the author of many articles on arthritis and the producer of two motion pictures: "The Intra-articular Injection of Hydrocortisone" and "The Diagnosis and Office Management of the Arthritides".

**Paul W.
Searles, M.D.**

Chicago Ill.

**Sponsored by
Georgia Society of
Anesthesiologists**



PAUL W. SEARLES, M.D., Chicago, Ill., will address the Surgery, E. E. N. T., and Anesthesia Joint Section on "The Role of Hypothermia in Anesthesia", a summary of which follows:

The role of hypothermia in anesthesia has assumed increasing importance in recent years. For the most part, this role has been played in the field of cardiovascular surgery. However, the purpose of this discussion is not only to bring out the usefulness of this method in this regard, but to point out some of the advantages it holds in other fields of surgery.

The various problems encountered in the use of hypothermia in anesthesia will be discussed and illustrated

by actual cases in which this method has been performed. Special consideration will be given the preoperative evaluation of the patient as well as the conduct of the anesthetic during the period of operation. In addition, post operative morbidity and mortality will be compared to other techniques of anesthesia.

On Monday, April 29th, Dr. Searles will speak to the Anesthesiology Section, at 2:30 p.m., on "Cardiac Anesthesia". Dr. Searles' summary follows:

The purpose of this discussion is to bring out the various problems encountered in conducting an anesthetic in a cardiac patient. Special emphasis will be placed on the problem of cardiac arrest. The relative value of the various anesthetic techniques which are used in cardiac surgery will be discussed. In addition, the problem of bypassing the heart will be illustrated by the cases we have performed to date with this technique.

Dr. Searles is a graduate of the University of Minnesota Medical School. After completing his internship, he received his postgraduate training in anesthesia as a fellow at the Mayo Clinic. He received the M.S. degree in anesthesiology from the University of Minnesota in 1936. Dr. Searles became Professor of Anesthesia at the University of Buffalo in 1942, a post he held until 1953 when he became Director of the Department of Anesthesia at Chicago's St. Luke's Hospital, the position he now holds.

**Mary S.
Sherman, M.D.**

New Orleans, La.

**Sponsored by
Georgia Orthopedic
Society**



MARY S. SHERMAN, M.D., New Orleans, La., is a featured speaker on Sunday, April 28th, in the meeting

of the Pediatrics, Orthopedics, and Radiology Joint Section. At 3:00 p.m. she will discuss "Some Common Skeletal Diseases in Children".

The clinical, radiological, and pathologic aspects of several disorders of childhood which are frequently missed or confused with more serious diseases will be discussed.

During the same meeting, Dr. Sherman will be a panelist to discuss "Modern Everyday Concepts of Scurvy and Rickets".

Dr. Sherman is an orthopedic surgeon and a member of the staff of the Ochsner Clinic, New Orleans. She is a graduate of The School of Medicine of the University of Chicago and is a member of the American Board of Orthopedic Surgery, the American Academy of Orthopedic Surgery, American College of Surgeons, and the American Orthopaedic Association.

**James V.
Warren, M.D.**

Durham, N. C.

**Sponsored by
American College of
Physicians and
Georgia Heart
Association**



JAMES V. WARREN, M.D., Durham, N. C., will address the Diabetes and Medicine Joint Session on Monday, April 29th, at 2:50 p.m.; his paper on "Recent Advances in our Knowledge of Coronary Heart Disease" is summarized here:

Despite many advances in preventive medicine and public health, the rising incidence of arteriosclerotic coronary heart disease is modern-day plague. Studies throughout the world have indicated the relative vulnerability of the American male and have suggested that our mode of life determines this high incidence of coronary arteriosclerotic disease. Attention has been focused in particular on the dietary habits of the American family and, in particular, upon the diet's fat content. There is considerable evidence, much of it circum-

stantial, relating the type of diet to the cholesterol level of the blood and in turn to the occurrence of arteriosclerosis. Although several recent studies have demonstrated impressively the effect of certain types of dietary fat on serum cholesterol level, the direct relationship of these effects on the course of coronary arteriosclerosis remains to be proven.

Knowledge regarding the possible etiologic factors in coronary disease has resulted in a recommendation by many physicians that patients with this disorder restrict the fat content of their diet and some instances add those fats of the "unsaturated" character (vegetable) which are missing from the ordinary American diet. Studies of recent years have adequately demonstrated the merits of anticoagulant therapy in the acute phase of myocardial infarction. More difficult to evaluate, but no less important, is the potential value of long-term anticoagulant therapy in individuals with either a history of myocardial infarction or angina pectoris. The role of estrogen therapy, thyroid depression, vasodilators, and surgical procedures will also be discussed. With the increasing incidence of disorders caused by coronary artery disease and widespread public anxiety regarding them, the physician must frequently face difficult diagnostic and therapeutic problems.

On Tuesday, April 30th, Dr. Warren will address the Diabetes, Chest, and Medicine Joint Section at 10:30 a.m. on "The Management of Severe Cardiac Failure". During the same meeting he will participate in a panel discussion of "The Management of Medical Emergencies". A summary of the paper on cardiac failure follows:

During recent years, the understanding of the pathophysiologic mechanisms involved in congestive failure has increased considerably. Along with this, there has been an increasing number of potent therapeutic agents. As a result, the physician now treats patients with congestive failure over a longer period of time, and to a point of cardiac insufficiency that was much less frequently seen in the years gone by. He must, however,

use particular care in the management of those patients with severe cardiac failure.

The basic principles of therapy, including rest, digitalis, and regulation of salt and water balance, are essentially the same as in early circulatory failure. Although there is considerable evidence to indicate that all digitalis products act by one basic mechanism, the wide variety of preparations available offer the physician a choice in the mode of medication but increase the possibilities of digitalis toxicity. Sodium restriction or depletion forms the backbone of the therapeutic program in severe and prolonged congestive failure. The occurrence of the so-called "low salt syndromes," or perhaps more accurately stated, "dilution syndromes," presents problems of recognition and, at times, alters therapy to reconstruct a normal electrolyte picture. Unfortunately, similar clinical states with diuretic unresponsiveness and clinical deterioration may result from either overly enthusiastic therapy or the course of the disease itself.

Dr. Warren is a native of Ohio and a graduate of Ohio State University and Harvard Medical School. He received postgraduate training in medicine at Peter Bent Brigham Hospital, Boston, and Harvard Medical School. He was Instructor in Medicine at Emory University School of Medicine, 1942-46; Assistant Professor of Medicine, Yale University Medical School, 1946-47; Professor of Physiology, Chairman of the Department of Physiology, and Associate Professor of Medicine, Emory University, 1947-51; Professor of Medicine, Emory, 1951-52; and Professor of Medicine, Duke University School of Medicine, 1952 to the present.

He is a member of the American Society for Clinical Investigation, the American Federation for Clinical Research (national president, 1952-53), the Southern Society for Clinical Research, the American Physiological Society, the Cardiovascular Study Section of the National Heart Institute, the editorial boards of *Circulation* and *American Heart Journal*, and the Association of American Physicians.

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VOTING RULES

By-Laws, Chapter V, Election of Officers

SECTION 3. METHOD. The President shall appoint a committee of not less than three Tellers immediately after the close of nominations, who shall have charge of the election. The Secretary shall have prepared in advance an official ballot and an official ballot box, which shall be kept in the custody of the Tellers Committee. One ballot only shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in the locked ballot box.

The candidates for office receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select by secret ballot the officer from the two candidates having the highest number of votes.

SECTION 4. TIME. Voting shall take place during the hours of the scientific program up to the beginning of the last meeting on the last day of the annual session. At that time the Committee of Tellers shall count the ballots and report their findings to the members.

The Program

SUNDAY AFTERNOON, APRIL 28

Social Events

NOTE: Make reservations in advance with chairman if possible.

12:00 GEORGIA PEDIATRIC SOCIETY LUNCHEON AND BUSI-

NESS MEETING (not a part of Official Program)
Manger Hotel

Howard J. Morrison, Savannah, Chairman

1:15 Neurology, Neurosurgery, and Psychiatry Section

(ALL PHYSICIANS INVITED)

Camellia Room, Hotel Manger

PRESIDING

William A. Smith, Atlanta

1:30 CEREBRAL ARTERIOVENOUS ANEURYSMS

John W. Kemble, Augusta

1:50 PITUITARY APOPLEXY

Fleming L. Jolley and Robert F. Mabon,
Atlanta

2:15 CHEMOPALLIDECTOMY: THE EFFECTS OF
THIS OPERATION UPON TREMOR, RIGIDITY,
AND OTHER EXTRAPYRAMIDAL MOVEMENT
DISORDERS

Irving S. Cooper, New York City

2:45 RECESS

3:00 PRESIDING

Joseph D. McElroy, Atlanta

3:00 COMMUNITY MENTAL HEALTH
DEVELOPMENT

Paul V. Lemkau, New York City

3:30 SUICIDE: A FOLLOW-UP STUDY OF
UNSUCCESSFUL ATTEMPTS

E. James McCranie, Augusta

3:45 PSYCHOTHERAPY WITH COUPLES—A
PRELIMINARY REPORT

Carl A. Whitaker, Atlanta

4:00 REPORT ON COMMITMENT LAWS OF
GEORGIA

MAG Mental Health Committee

1:30 Pediatrics, Orthopedics, and Radiology Joint Section

(ALL PHYSICIANS INVITED)

Ballroom, Hotel DeSoto

PRESIDING

Howard J. Morrison, Savannah

2:00 RESPIRATORY PROBLEMS OF THE NEWBORN
INCLUDING THE HYALINE MEMBRANE
SYNDROME

Stewart H. Clifford, Brookline, Mass.

2:30 ROENTGENOLOGICAL ASPECTS OF THE
DIFFERENTIAL DIAGNOSIS OF SCLEROSING
LESIONS OF BONE IN INFANTS AND
CHILDREN

John R. Hodgson, Rochester, Minn.

3:00 SOME COMMON SKELETAL DISEASES IN
CHILDREN

Mary S. Sherman, New Orleans, La.

3:30 RECESS

3:40 PANEL: MODERN EVERYDAY CONCEPTS
OF SCURVY AND RICKETS

MODERATOR

Howard J. Morrison, Savannah

PANELISTS

Stewart H. Clifford, Brookline, Mass.

John R. Hodgson, Rochester, Minn.

Mary S. Sherman, New Orleans, La.

1:30 Surgery, E.E.N.T., and Anesthesiology Joint Section

(ALL PHYSICIANS INVITED)

Veranda Room, Hotel Manger

PRESIDING

J. Kirk Train, Jr., and C. W. Westerfield,
Savannah

2:00 HAZARDS OF STEROID THERAPY IN THE
SURGICAL PATIENT

Robert J. Coffey, Washington, D. C.

2:45 GLAUCOMA IN GENERAL PRACTICE

Braswell E. Collins, Macon

3:00 THYROTOXIC EXOPHTHALMOS

Franklin P. Bousquet, Savannah

3:15 TUMORS AND CYSTS OF THE HEAD AND
NECK

A. C. Furstenberg, Ann Arbor, Mich.

4:00 THE ROLE OF HYPOTHERMIA IN
ANESTHESIA

Paul W. Searles, Chicago, Ill.

4:45 A REPORT ON THE ANESTHETIC STUDY
COMMISSION

Lester Rumble, Jr., Atlanta

4:30 MAG Delegates Registration

Ballroom, Hotel DeSoto

5:00 House of Delegates Meeting

Ballroom, Hotel DeSoto

PRESIDING

Thomas W. Goodwin, Augusta, Speaker
of the House

ORDER OF BUSINESS

(see *Delegates' Handbook*)

MAG AUXILIARY PRESIDENT'S REPORT

Mrs. Walker L. Curtis, College Park

Social Events
(Not a part of Official Program)

Sunday Night, April 28

NOTE: Make reservations in advance with chairman if possible.

5:30 GEORGIA STATE OBSTETRICAL AND GYNCOLOGICAL SOCIETY SOCIAL HOUR
Oglethorpe Club, 450 Bull Street
Albert J. Kelley, Savannah, Chairman

6:00 GEORGIA PSYCHIATRIC ASSOCIATION SOCIAL HOUR AND DINNER (Branch of American Psychiatric Association)
Manger Hotel
William A. Smith, Atlanta, Chairman

6:30 GEORGIA PEDIATRIC SOCIETY SOCIAL HOUR AND DINNER
Manger Hotel
Howard J. Morrison, Savannah, Chairman

6:30 GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS SOCIAL HOUR AND DINNER (All Industrial Surgeons invited)
Manger Hotel
Julian Quattlebaum, Savannah, Chairman

7:00-8:00 HOUSE OF DELEGATES AND EXHIBITORS SOCIAL HOUR (Wives invited)
Jewish Educational Alliance, Abercorn Street and DeRenne Avenue

7:00 GEORGIA RADIOLOGICAL SOCIETY BUFFET DINNER
Veranda Room, Manger Hotel
John B. Rabun, Savannah, Chairman

8:00 GEORGIA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY DINNER
Purple Tree Lounge, Manger Hotel
J. Kirk Train, Jr., Savannah, Chairman

MONDAY MORNING, APRIL 29

8:15 General Session (G. P. Day)

(ALL PHYSICIANS INVITED)

Ballroom, Hotel DeSoto

PRESIDING

Harold Smith, Savannah

8:30 INVOCATION

Rev. Henry S. Brooks, Pastor, Epworth
Methodist Church, Savannah

8:35 WELCOME

Hon. W. Lee Mingledorff, Jr., Mayor of
Savannah

Walter E. Brown, Savannah, President,
Georgia Medical Society

**8:45 RECOMMENDATIONS TO THE G. P. DOING
GENERAL SURGERY**

Robert J. Coffey, Washington, D. C.

9:15 OFFICE GYNCOLOGY

Frank R. Lock, Winston-Salem, N. C.

**9:45 PERINATAL MORTALITY AND MORBIDITY IN
POSTMATURITY WITH EMPHASIS ON
OBSTETRICAL MANAGEMENT**

Stewart H. Clifford, Brookline, Mass.

10:15 RECESS

**10:30 ROENTGENOLOGIC ASPECTS OF BLEEDING
LESIONS OF THE GASTROINTESTINAL
TRACT IN INFANTS AND CHILDREN**

John R. Hodgson, Rochester, Minn.

**11:00 THE DIFFERENTIAL DIAGNOSIS AND OFFICE
MANAGEMENT OF THE PATIENT WITH
RHEUMATOID ARTHRITIS**

William B. Rawls, New York City

**9:00 Georgia Radiological Society Business
Session and Film Reading Session**

Camellia Room, Hotel Manger

PRESIDING

Robert M. Tankesley, Atlanta

11:45 MAG General Business Session

(ALL MAG AND AUXILIARY MEMBERS AND
GUESTS INVITED)

Ballroom, Hotel DeSoto

PRESIDING

Hal M. Davison, Atlanta, President, Medical
Association of Georgia

11:45 Equen Memorial Lectureship

A LOOK TO THE FUTURE

A. C. Furstenberg, Ann Arbor, Mich.

12:10 PRESIDING

Carl C. Aven, Marietta, First Vice-President

PERSPECTIVE

Hal M. Davison, Atlanta, President

PRESIDING

Hal M. Davison, Atlanta, President

NOMINATION OF OFFICERS

(*Announcement of Tellers Committee*)

President-Elect

First Vice-President

Second Vice-President

Secretary

AMA Delegate (term beginning January
1, 1958)

AMA Alternate (term beginning Janu-
ary 1, 1958)

Councilor, Ninth District

Vice-Councilor, Ninth District

Councilor, Tenth District

Vice-Councilor, Tenth District

VOTE EARLY

**1:00 BALLOT BOX OPENS—location and rules
posted on Official Bulletin Board**

Social Events

(Not a part of Official Program)

Monday Noon, April 29

NOTE: Make reservations in advance with chairman if possible.

12:00 GEORGIA ASSOCIATION OF PATHOLOGISTS LUNCHEON AND BUSINESS MEETING
Manger Hotel
Lee Howard, Jr., Savannah, Chairman

12:30 GEORGIA UROLOGICAL SOCIETY SOCIAL HOUR AND LUNCHEON
Oglethorpe Club, 450 Bull Street
J. Z. McDaniel, Albany, Chairman

1:00 GEORGIA DIABETES ASSOCIATION LUNCHEON
Manger Hotel
C. Raymond Arp, Atlanta, Chairman

1:00 GEORGIA RADIOLOGICAL SOCIETY LUNCHEON
Camellia Room, Manger Hotel
John B. Rabun, Savannah, Chairman

1:00 GEORGIA STATE OBSTETRICAL AND GYNECOLOGICAL SOCIETY AND GEORGIA ACADEMY OF GENERAL PRACTICE JOINT LUNCHEON
Sapphire Room, Hotel DeSoto
Albert J. Kelley, Savannah and
Harold M. Smith, Savannah, Chairman

1:00 GEORGIA SOCIETY OF ANESTHESIOLOGISTS LUNCHEON
Manger Hotel
W. Loyd Osteen, Savannah, Chairman

MONDAY AFTERNOON, APRIL 29

1:45 Obstetrics and Gynecology and General Practice Joint Section

(ALL PHYSICIANS INVITED)

Sapphire Room, Hotel DeSoto

PRESIDING

Hartwell Boyd, Atlanta

2:00 HYDATIDIFORM MOLE: A REVIEW OF FIVE CASES

W. Vernon Skiles, Atlanta

2:20 PROBLEMS IN MATERNAL MORTALITY

Frank R. Lock, Winston-Salem, N. C.

2:50 PANEL: MATERNAL DEATHS IN GEORGIA DURING 1956

MODERATOR

Samuel R. Poliakoff, Atlanta

PANELISTS

Frank R. Lock, Winston-Salem, N. C.

Peter Hydrick, College Park

Hugh J. Bickerstaff, Columbus

John R. McCain, Atlanta

4:40 BUSINESS MEETING

2:15 Anesthesiology Section

(ALL PHYSICIANS INVITED)

Colonial Room, Hotel DeSoto

PRESIDING

W. Loyd Osteen, Savannah

2:30 CARDIAC ANESTHESIA

Paul W. Searles, Chicago, Ill.

3:30 SOME CLINICAL EXPERIENCE WITH FLUOTHANE—A NEW NON-FLAMMABLE ANESTHETIC

David A. Davis, Chapel Hill, N. C.

4:00 THE CARDIOVASCULAR ACTION OF SOME DRUGS OF INTEREST TO THE ANESTHESIOLOGIST

Kenneth Boniface, Augusta

4:30 THE USE OF E.E.G. IN ANESTHESIA

Curtis Pearcy, Augusta

5:00 A SUMMARY OF 15,000 CASES USING SUCCINYLCHOLINE AND NITROUS OXIDE

Lester Rumble, Jr., Atlanta

BUSINESS MEETING

2:15 Diabetes and Medicine Joint Section

(ALL PHYSICIANS INVITED)

Ballroom, Hotel DeSoto

PRESIDING

C. Raymond Arp, Atlanta

2:30 THE MARFAN SYNDROME, CASE PRESENTATION

Arthur M. Knight, Jr., Waycross

2:50 RECENT ADVANCES IN OUR KNOWLEDGE OF CORONARY HEART DISEASE

James V. Warren, Durham, N. C.

3:20 DIABETIC ACIDOSIS

Clifford F. Gastineau, Rochester, Minn.

3:50 LUNG AND PERICARDIAL BIOPSY

Donald B. Effler, Cleveland, Ohio

4:20 DIAGNOSTIC CARDIAC CATHETERIZATION

Manuel N. Cooper, Atlanta

4:40 THE CLINICAL ASPECTS OF THE USE OF RADIOACTIVE IODINE IN THE TREATMENT OF CHRONIC PULMONARY INSUFFICIENCY

B. Shannon Gallaher, Augusta

2:15 Radiology Section

(ALL PHYSICIANS INVITED)

Camellia Room, Hotel Manger

PRESIDING

Robert M. Tankesley, Atlanta

**2:30 CHOLECYSTOGRAPHY AND
CHOLANGIOGRAPHY**

John R. Hodgson, Rochester, Minn.

**3:00 CANCER METASTASES AFFECTING THE
LARGE INTESTINE**

Russell Wigh, Augusta

2:15 Surgery and Pathology Joint Section

(ALL PHYSICIANS INVITED)

Veranda Room, Hotel Manger

PRESIDING

Lee Howard, Jr., Savannah

**2:30 THE RESULTS OF SURGICAL TREATMENT
OF CARCINOMA OF THE THYROID, REPORT
OF 100 CASES**

David Henry Poer, John E. Skandalakis,
and Edgar O'Connor Rand, Atlanta

**3:00 THE RELATION OF POLYPS TO CANCER OF
THE COLON**

Robert J. Coffey, Washington, D. C.

**3:45 THE SURGEON, THE PATHOLOGIST, THE
PATIENT, AND THE DIAGNOSIS OF EARLY
CANCER**

L. D. Stoddard, Augusta

4:30 ASPIRATION BIOPSY

John T. Godwin, Atlanta

**4:45 TRANSFUSION REACTIONS AND THEIR
PREVENTION**

George Lester Forbes, Atlanta

2:15 Urology Section

(ALL PHYSICIANS INVITED)

Oglethorpe Club, 450 Bull Street

PRESIDING

J. Z. McDaniel, Albany

2:30 HYPOSPADIAS

Ormond S. Culp, Rochester, Minn.

3:30 PYELOGRAM CLINIC**MONDAY EVENING, APRIL 29****Social Events**

(Not a part of Official Program)

NOTE: Make reservations in advance with chairman if possible.

5:30 EMORY UNIVERSITY SCHOOL OF MEDICINE ALUM-
NI SOCIAL HOUR AND BANQUET
Manger Hotel

6:30 MEDICAL COLLEGE OF GEORGIA ALUMNI SOCIAL
HOUR AND BANQUET
Ballroom, Hotel DeSoto

**8:15 General Session Reconvened
(G. P. Day)**

(ALL MAG AND AUXILIARY MEMBERS AND
GUESTS INVITED)

Gold Room, Hotel DeSoto

PRESIDING

Maurice F. Arnold, Hawkinsville

8:30 SOCIAL SECURITY AND THE PHYSICIAN

Mr. James W. Murray, Atlanta, Regional
Representative, Bureau of Old Age and
Survivors Insurance, Social Security
Administration

Mr. C. Joseph Stetler, Chicago, Director,
AMA Law Department

9:15 QUESTION AND ANSWER PERIOD**TUESDAY MORNING, APRIL 30****Social Events**

(Not a part of Official Program)

NOTE: Make reservations in advance with chairman if possible.

7:45 GEORGIA CHAPTER, INTERNATIONAL COLLEGE OF
SURGEONS (Not a part of official program)

Georgian Room, Hotel DeSoto
John W. Turner, Atlanta, Chairman

**8:15 Surgery and Industrial Surgery Joint
Section**

(ALL PHYSICIANS INVITED)

Gold Room, Hotel DeSoto

PRESIDING

Robert Lee Oliver, Savannah

**8:30 THE CHALLENGE OF THE FISTULA-IN-ANO,
A KODACHROME PRESENTATION**

Leonard J. Rabhan, Savannah

**8:45 POWER LAWN MOWER INJURIES IN
GEORGIA IN 1956**

John N. McClure, Jr., Atlanta

- 9:00 BACK INJURIES
Harvey Nelson, Minneapolis, Minn.
- 9:45 SURGICAL TREATMENT OF DUODENAL
ULCER
Robert J. Coffey, Washington, D. C.
- 10:30 BURNS—PRESENTATION OF A CASE
John G. Sharpley, Savannah
- 10:45 JUXTA-ESOPHAGEAL GASTRIC
DIVERTICULUM
Duncan Shepard, Atlanta
- 11:00 HAND INJURIES—FUNDAMENTAL
PRINCIPLES OF CONSERVATIVE TREATMENT
Southgate Leigh, Jr., Norfolk, Va.
- 8:15 Diabetes, Chest, and Medicine Joint
Section**
(ALL PHYSICIANS INVITED)
Ballroom, Hotel DeSoto
PRESIDING
William A. Hopkins, Atlanta
- 8:30 MIDDLE LOBE SYNDROME
Robert H. Vaughan, Columbus
- 8:50 SURGICAL ASPECTS OF HIATAL HERNIA
William E. Van Fleit, Emory University
- 9:10 A COMBINED RIGHT THORACO-ABDOMINAL
APPROACH TO HIGH ESOPHAGEAL LESIONS
Jerome A. Cope and Robert G. Ellison,
Augusta
- 9:45 RECESS

- 10:00 ELECTIVE CARDIAC ARREST
Donald B. Effler, Cleveland, Ohio
- 10:30 THE MANAGEMENT OF SEVERE CARDIAC
FAILURE
James V. Warren, Durham, N. C.
- 11:00 PANEL: THE MANAGEMENT OF MEDICAL
EMERGENCIES
MODERATOR
T. A. McGoldrick, Jr., Savannah
PARTICIPANTS
Donald B. Effler, Cleveland, Ohio
Clifford F. Gastineau, Rochester, Minn.
James V. Warren, Durham, N. C.

*Visit the exhibits and register with the
exhibitors—these are the people who help
finance your annual session.*

- 12:00 Abner Wellborn Calhoun Memorial
Lectureship**
(ALL PHYSICIANS INVITED)
Ballroom, Hotel DeSoto
PRESIDING
Glenville Giddings, Atlanta
THROMBOSIS AND THROMBOPHLEBITIS
Chester S. Keefer, Boston, Mass.

Social Events

(Not a part of Official Program)

Tuesday Noon, April 30

NOTE: Make reservations in advance with chairman if possible.

- 1:00 GEORGIA CHAPTER, AMERICAN COLLEGE OF CHEST
PHYSICIANS LUNCHEON
Hotel DeSoto
William A. Hopkins, Atlanta, Chairman

- 1:00 GEORGIA CHAPTER, AMERICAN COLLEGE OF PHYSI-
CIANS AND GEORGIA HEART ASSOCIATION JOINT
LUNCHEON
Manger Hotel
T. A. McGoldrick, Jr., Savannah

TUESDAY AFTERNOON, APRIL 30

- 2:30 House of Delegates Second Meeting
(Recessed)**
Ballroom, Hotel DeSoto

- PRESIDING
Thomas W. Goodwin, Augusta, Speaker
ORDER OF BUSINESS
(see *Delegates Handbook*)

**Please check the Official Bulletin Board
for details of other Social Events
which may not have been listed here**

WEDNESDAY MORNING, MAY 1

Be sure to vote
Ballot box closes 8:45

8:45 MAG General Session

Ballroom, Hotel DeSoto

PRESIDING

Hal M. Davison, Atlanta, President

9:00 ACCIDENTS IN AND AROUND THE HOME*

MODERATOR

Herbert S. Alden, Atlanta (Dermatology)

PARTICIPANTS

Joe M. Bosworth, Atlanta (Industrial Medicine)

Howard J. Morrison, Savannah (Pediatrics)

Paul L. Reith, Warm Springs (Orthopedics)

Fred E. Murphy, Jr., Thomasville (General Surgery and Orthopedics)

Mr. Henry C. Steed, Atlanta (Home Safety, Georgia Department of Public Health)

* This is the first of a series of MAG programs destined to institute preventive measures for accidents at home, work, recreation, and travel.

10:30 MAG General Business Session

(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)

Ballroom, Hotel DeSoto

PRESIDING

Hal M. Davison, Atlanta, President

PRESENTATION OF 50-YEAR CERTIFICATES

Hal M. Davison, Atlanta, President

PRESENTATION OF HARDMAN AWARD

Mr. Lamartine C. Hardman, Commerce

PRESENTATION OF CERTIFICATES OF APPRECIATION

David Henry Poer, Atlanta,
Secretary-Treasurer

PRESENTATION OF PRESIDENT'S KEY

Allen H. Bunce, Atlanta

PRESENTATION OF GOLF AWARDS

John G. Sharpley, Savannah

SELECTION OF 1958 MEETING SITE

ANNOUNCEMENT OF ELECTION RESULTS

C. H. Richardson, Macon, Chairman, Tellers Committee

INSTALLATION OF OFFICERS

ADJOURNMENT OF *103RD ANNUAL SESSION

See you at the Annual Session!

You are invited to visit Memorial Hospital

MR. DANIEL E. GAY, ADMINISTRATOR of Memorial Hospital of Chatham County, Savannah, invites all physicians, members of the Woman's Auxiliary, and guests of the Annual Session to visit this new 300-bed hospital. The hospital, which has been in operation for just a little over a year, is completely air-conditioned. It was accredited by the Joint Commission on Accreditation of Hospitals and approved for internship training in less than 13 months of operation.

In November 1956, Memorial Hospital of Chatham County was chosen the "Modern Hospital of the Month" by *Modern Hospital Magazine*.

For more details about this hospital and other historical facts about Savannah, be sure to read the article by Anne McH. Hopkins, Savannah, which will appear in the April issue of the *Journal*.



Memorial Hospital of Chatham County
Savannah, Georgia

Woman's Auxiliary to the Medical Association of Georgia 32nd Annual Meeting

April 28 - May 1, 1957 — Savannah

President's Invitation

MEMBERS OF THE WOMAN'S AUXILIARY to the Medical Association of Georgia, it is my happy privilege to greet you with a cordial invitation to attend the Annual Meeting of the Woman's Auxiliary, to be held April 28-May 1, 1957, in the historic and hospitable City of Savannah.

As you will note, this brief program outline indicates a convention of unusual inspiration and friendly fellowship.

Mrs. Walker L. Curtis

President, Woman's Auxiliary to the
Medical Association of Georgia



Mrs. Curtis



Mrs. Porter

Welcome to Savannah

THE WOMAN'S AUXILIARY to the Georgia Medical Society and the City of Savannah welcome you to the Thirty-Second Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia.

A full schedule of entertainment has been planned for you. It will be our pleasure to assist you whenever possible in order that you may enjoy your visit to Savannah to the fullest extent.

Sincerely,

Mrs. John Emerson Porter

President, Woman's Auxiliary to the
Georgia Medical Society

SUNDAY, APRIL 28

10:00 Registration
to
5:00 Lobby, Hotel DeSoto

1:00 Pre-Convention Executive Board Meeting—Dutch Luncheon
(For 1956-57 officers, chairmen, district managers, county presidents, county presidents-elect, state past presidents, and councilor to SMA Auxiliary)
Gold Room, Hotel DeSoto

PRESIDING

Mrs. Walker L. Curtis, College Park,
President

INVOCATION

Mrs. William R. Dancy, Savannah

PLEDGE OF LOYALTY

Mrs. Lehman W. Williams, Savannah

BUSINESS SESSION

5:00 Joint Meeting—MAG House of Delegates and Woman's Auxiliary
Ballroom, Hotel DeSoto

PRESIDING

Thomas W. Goodwin, Augusta, Speaker
of the House

ORDER OF BUSINESS (See MAG *Delegates Handbook*)

AUXILIARY PRESIDENT'S REPORT

Mrs. Walker L. Curtis, College Park

MONDAY, APRIL 29

8:30 Registration

to
3:30 Lobby, Hotel DeSoto

9:30 General Meeting

St. John's Parish House (across the square
from the Hotel DeSoto)

CALL TO ORDER

Mrs. Walker L. Curtis, College Park,
President

INVOCATION

Dr. L. G. Cloverdon, Pastor, First Baptist
Church, Savannah

PLEDGE OF LOYALTY

Mrs. Ralph Fowler, Marietta

WELCOME

Mrs. John E. Porter, Savannah, President,
Woman's Auxiliary to the Georgia
Medical Society

RESPONSE

Mrs. James K. Fancher, Atlanta, President,
Woman's Auxiliary to the Fulton County
Medical Society

INTRODUCTION OF HONOR GUESTS AND

PAST PRESIDENTS

Mrs. W. G. Elliott, Cuthbert

PRESENTATION OF CONVENTION PLANS

AND CHAIRMEN

Mrs. W. Loyd Osteen, Savannah, General
Chairman

INTRODUCTION OF PAGES FOR THE DAY

Mrs. William W. Osborne, Savannah,
Chairman

REPORT OF ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

Edgar M. Dunstan, M.D., Atlanta, Chairman

GREETINGS

Hal M. Davison, M.D., Atlanta, President,
Medical Association of Georgia

INTRODUCTION OF GUEST SPEAKER

Mrs. Eustace Allen, Atlanta, Past President,
Woman's Auxiliary to the American
Medical Association

LOOKING FOR ATTIC TREASURES

Mrs. Paul C. Craig, Wyomissing, Pa.,
President-elect, Woman's Auxiliary to
the American Medical Association

Business Session

CONVENTION RULES OF ORDER

Mrs. Shelley C. Davis, Atlanta,
Parliamentarian

ROLL CALL

MINUTES

Mrs. Joe J. Arrendale, Cornelia, Recording
Secretary

Reports

PRESIDENT

Mrs. Walker L. Curtis, College Park

PRESIDENT-ELECT (Presentation of new auxiliary)

Mrs. John L. Elliott, Savannah

TREASURER (Including report of auditor)

Mrs. Hayward S. Phillips, Augusta

ADDENDUM REPORTS

COMPLETE REPORTS (see 1956-1957 Annual Report)

NEW BUSINESS

RECOMMENDATIONS OF EXECUTIVE BOARD

REVISIONS

Mrs. W. Bruce Schaefer, Toccoa, Chairman

REPORT OF CREDENTIALS COMMITTEE

Mrs. Hollis E. Puckett, Savannah, Chairman

MEMORIAL SERVICE

Mrs. Lee Howard, Sr., Savannah, Chairman

ANNOUNCEMENTS

ADJOURNMENT

12:30 Dutch Luncheon

(For Past Presidents of the Woman's
Auxiliary to the MAG)

Oglethorpe Club, 450 Bull Street

PRESIDING

Mrs. Robert C. Major, Augusta, Immediate
Past President

2:30 Tour of Historic Savannah and Tea to 4:30 at Wormsloe (home of Mrs. Craig Barrow)

Sponsored by the Woman's Auxiliary
to the Georgia Medical Society for
Auxiliary Convention Members. (Trans-
portation furnished from Hotel DeSoto,
leaving at 2:30 p.m., returning by 4:30.
Gentlemen cordially invited.)

RECEIVING AT TEA

Mrs. John E. Porter, Savannah, President,
GMS Auxiliary

Mrs. Walker L. Curtis, College Park,
President, MAG Auxiliary

Mrs. Paul C. Craig, Wyomissing, Pa.,
President-elect, AMA Auxiliary

Mrs. Oscar W. Robinson, Paris, Texas,
President, SMA Auxiliary

Mrs. John L. Elliott, Savannah, President-
elect, MAG Auxiliary

Mrs. Hal Davison, Atlanta, Wife of MAG
President

Mrs. W. Bruce Schaefer, Toccoa, Wife of
MAG President-elect

Mrs. W. Loyd Osteen, Savannah, General
Chairman of Convention

Mrs. Walter Brown, Savannah, General
Co-chairman of Convention

Mrs. Harry Rollings, Savannah, Chairman
of Tea

Mrs. Thomas Amburgey, Savannah,
Chairman of Tour

MONDAY NIGHT, APRIL 29

**8:15 G. P. Day General Session (Joint
Meeting with MAG)
(Auxiliary members and guests invited)**
Gold Room, Hotel DeSoto

PRESIDING

Maurice F. Arnold, M.D., President, Georgia
Academy of General Practice

8:30 SOCIAL SECURITY AND THE PHYSICIAN

Mr. James W. Murray, Atlanta, Regional
Representative, Bureau of Old-age and
Survivors Insurance, Social Security
Administration

Mr. C. Joseph Stetler, Chicago, Ill., Director,
AMA Law Department

9:15 QUESTION AND ANSWER PERIOD

TUESDAY, APRIL 30

9:00 Registration

to
12:30 *Lobby, Hotel DeSoto*

9:30 General Meeting

St. John's Parish House

CALL TO ORDER

Mrs. Walker L. Curtis, College Park,
President

INVOCATION

The Reverend G. Edward Haynsworth,
Rector, St. Thomas Episcopal Church,
Isle of Hope

PLEDGE OF LOYALTY

Mrs. J. R. S. Mays, Macon

INTRODUCTION OF PAGES FOR THE DAY

Mrs. William W. Osborne, Savannah

ANNOUNCEMENTS, CONVENTION PLANS

Mrs. W. Loyd Osteen, Savannah,
Convention Chairman

INTRODUCTION OF GUEST SPEAKER

Mrs. Leo Smith, Waycross, Councilor from
Georgia to the Auxiliary to the Southern
Medical Association

ADDRESS

Mrs. Oscar W. Robinson, Paris, Texas,
President, Woman's Auxiliary to the
Southern Medical Association

**THE MEDICAL ASSOCIATION OF GEORGIA
AND ITS AUXILIARY IN 1957-58**

W. Bruce Schaefer, M.D., Toccoa,
President-elect, MAG

Business Session

ROLL CALL AND MINUTES

Mrs. Joe J. Arrendale, Cornelia, Recording
Secretary

**REPORT OF BY-LAWS AND PROCEDURE
COMMITTEE**

Mrs. W. Bruce Schaefer, Toccoa, Chairman

**REPORT OF BUDGET AND FINANCE
COMMITTEE**

Mrs. W. G. Elliott, Cuthbert, Chairman

REPORT OF RESOLUTIONS COMMITTEE

Mrs. J. Lon King, Jr., Macon, Chairman

REPORT OF CREDENTIALS COMMITTEE

Mrs. Hollis E. Puckett, Savannah, Chairman

REPORT OF COURTESY COMMITTEE

Mrs. Ennis W. Waldemayer, Americus,
Chairman

REPORTS OF AWARDS COMMITTEES

ACHIEVEMENT

Mrs. Samuel Victor, Waycross, Chairman

DOCTORS' DAY

Mrs. Harold M. Smith, Savannah,
Chairman

MRS. J. BONAR WHITE SCRAPBOOK

Mrs. T. A. Sappington, Thomaston,
Chairman

MARIE S. BURNS SAFETY

Mrs. W. Loyd Osteen, Savannah,
Chairman

**BRAWNER TROPHY FOR GENERAL
EXCELLENCE**

Mrs. Robert C. Major, Augusta,
Chairman

REPORT OF NOMINATING COMMITTEE

Mrs. Robert C. Major, Augusta, Chairman

ELECTION OF OFFICERS

INSTALLATION OF OFFICERS

Mrs. W. Bruce Schaefer, Toccoa, Past
President

PRESENTATION OF PRESIDENT'S PIN
 Mrs. Walker L. Curtis, College Park,
 Retiring President
 INAUGURAL ADDRESS—ANNOUNCEMENT
 OF 1957-58 CHAIRMEN
 Mrs. John L. Elliott, Savannah, President
 PRESENTATION OF PAST PRESIDENT'S PIN
 Mrs. Joseph Yampolsky, Atlanta
 ANNOUNCEMENTS
 ADJOURNMENT

1:00 Luncheon—Fashion Show
 (For Auxiliary Convention Members)
Oglethorpe Hotel
 (Transportation furnished—leaving
 Hotel DeSoto at 12:30 p.m.)
 PRESIDING
 Mrs. Walker L. Curtis, College Park,
 President
 INVOCATION
 Mrs. James N. Brawner, Atlanta

TUESDAY NIGHT, APRIL 30

6:30 Georgia Medical Society Social Hour
 (Sponsored by the Union Bag-Camp
 Paper Corporation)
Patio, Hotel DeSoto

**7:30 President's Banquet, Medical
 Association of Georgia**
Ballroom, Hotel DeSoto

10:00 Music and Dancing

WEDNESDAY, MAY 1

**8:30 Post-Convention Executive Board
 Dutch Breakfast**
 (For 1957-58 officers, chairmen, district
 managers, county presidents, county
 presidents-elect, state past presidents,
 and councilor to SMA Auxiliary)
Gold Room, Hotel DeSoto

PRESIDING
 Mrs. John L. Elliott, Savannah, President

10:30 Joint General Business Session
 (All MAG and Auxiliary Members and
 Guests)
Ballroom, Hotel DeSoto

PRESIDING
 Hal M. Davison, M.D., Atlanta, President,
 MAG

PRESENTATION OF 50-YEAR CERTIFICATES
 Hal M. Davison, M.D., Atlanta

PRESENTATION OF HARDMAN AWARD
 Mr. Lamartine C. Hardman, Commerce
 PRESENTATION OF CERTIFICATES OF
 APPRECIATION
 David Henry Poer, M.D., Atlanta,
 Secretary-Treasurer

PRESENTATION OF PRESIDENT'S KEY
 Allen H. Bunce, M.D., Atlanta

PRESENTATION OF GOLF AWARDS
 John G. Sharpley, M.D., Savannah

SELECTION OF 1958 MEETING SITE

ANNOUNCEMENT OF ELECTION RESULTS
 C. H. Richardson, M.D., Macon
 Chairman, Tellers Committee

INSTALLATION OF MAG OFFICERS

ADJOURNMENT OF *103RD ANNUAL
 SESSION

**NOTE: Tickets are available at the Registration Desk
 for Auxiliary Convention Members for (1) Monday**

**afternoon Tour of Historic Savannah and Tea, and
 (2) Tuesday Luncheon-Fashion Show.**

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
4. Badges must be worn by members of the voting body during all general sessions of the convention.
5. Delegates' privileges are not transferable.
6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by the persons making and seconding the motion.
7. All original motions on resolutions shall be made by submitting two copies, one to the Resolutions Committee and one to the Recording Secretary.
8. All persons appearing on the program must be seated near the platform when the session opens.

Whispering conversations greatly retard the business of the meeting. Order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced.

ORGANIZATION

of the

Woman's Auxiliary to the Medical Association of Georgia

Officers, 1956-1957

President—Mrs. Walker L. Curtis.....	College Park
President-Elect—Mrs. John L. Elliott.....	Savannah
First Vice-President—Mrs. Luther H. Wolff.....	Columbus
Second Vice-President—Mrs. Ted F. Leigh.....	Atlanta
Third Vice-President—Mrs. T. A. Sappington.....	Thomaston
Corresponding Secretary—Mrs. Evert A. Bancker.....	Atlanta
Recording Secretary—Mrs. Joe J. Arrendale.....	Cornelia
Treasurer—Mrs. Hayward S. Phillips.....	Augusta
Historian—Mrs. Max Mass.....	Macon
Parliamentarian—Mrs. Shelley C. Davis.....	Atlanta

Advisory Committee

Dr. Edgar M. Dunstan, Chairman.....	Atlanta
Dr. Hal M. Davison, <i>ex officio</i>	Atlanta
Dr. W. Bruce Schaefer, <i>ex officio</i>	Toccoa
Dr. Walker L. Curtis.....	College Park
Dr. Shelley C. Davis.....	Atlanta
Dr. Robert C. Major.....	Augusta
Dr. Leo Smith.....	Waycross

Standing Committee Chairmen

Achievement Award—Mrs. Samuel Victor.....	Waycross
American Medical Education Foundation— Mrs. Virgil Williams.....	Griffin
Archives—Mrs. A. Worth Hobby.....	Atlanta
Brawner Trophy—Mrs. Robert C. Major.....	Augusta
Budget and Finance—Mrs. W. G. Elliott.....	Cuthbert
Bulletin—Mrs. W. P. Rhyne.....	Albany
By-Laws and Procedures Revisions— Mrs. W. Bruce Schaefer.....	Toccoa
Civil Defense—Mrs. F. Kells Boland.....	Atlanta
Doctors' Day—Mrs. Harold Smith.....	Savannah
Editorial—Mrs. Charles M. Huguley, Jr.....	Atlanta
Legislation—Mrs. R. Y. Clark.....	Marietta
Mental Health—Mrs. Charles R. Smith.....	Columbus
Organization—Mrs. John L. Elliott.....	Savannah
Program—Mrs. Luther H. Wolff.....	Columbus
Public Relations—Mrs. Milford Hatcher.....	Macon
Recruitment—Mrs. Phil Astin.....	Carrollton
Research in Romance of Medicine—Mrs. W. P. Stoner.....	Sylvester
Safety—Mrs. W. Loyd Osteen.....	Savannah
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Mrs. J. Lon King, Macon

Pledge of Loyalty

to the

Woman's Auxiliary

to the

Medical Association of Georgia

I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of Georgia. I will support its activities, protect its reputation, and ever sustain its high ideals.

Collect

"Keep us, O God, from pettiness; let us be large in thought, word and deed.

Let us be done with fault-finding and leave off selfseeking.

May we put away all pretense and meet each other face to face without self-pity and without prejudice.

May we never be hasty in judgment, and always generous.

Let us take time for all things; make us to grow calm, serene, gentle.

Teach us to put into action our better impulses, straightforward and unafraid.

Grant that we may realize it is the little things that create differences; that in the big things of life we are one.

And may we strive to reach and to know the great common woman's heart of us all, and, O, Lord God, let us not forget to be kind."

Diagnostic Cardiac Catheterization—1957

A. CALHOUN WITHAM, M.D., Augusta, Ga.

THIS AMAZING TECHNIC has passed its 15th anniversary. The specialized laboratories required have sprouted in profusion across the land, and the indications, advantages, limitations, and dangers should occasionally be reviewed. The method still grows and the final evaluation of such refinements as tracking the course of catheter-injected radiopaque, radioactive, and colored materials through the heart, intracardiac electrocardiography and phonocardiography, and left heart catheterization is impatiently awaited.

The method in no way supplants time-honored clinical disciplines and does not often supply a complete answer to a diagnostic problem by itself. The data must be interpreted in the light of all other available studies. The conclusions drawn are basically physiological. The manipulative technics are not infallible; occasionally important heart chambers cannot be entered. Differences in blood oxygen content between heart chambers may be of questionable significance or inconstant due to incomplete mixing of several blood streams of varying oxygen content entering the chambers (particularly the right atrium). The gasometric assays are treacherous. In patients cyanotic because of venous blood streaming into the left heart, catheterization data may not indicate the site of this shunt unless the instrument can be made to intubate the abnormal communication.

The sort of information sought by cardiac catheterization is of three sorts: (1) Abnormal pathways may be indicated by the probing of the radiopaque catheter tip. (2) The site of left-to-right intracardiac shunts can be demonstrated by abnormally high oxygen content of heart chambers. The minute volume of blood flowing in various directions may be estimated. (3) The pulse contours and measured pressure levels of the chambers help identify catheter position and obstructions in the right heart or pulmonary artery; and they indicate the state of right-sided valvular functions.

The trend at present is towards catheterizing almost all cases of congenital heart disease because the newer operative technics now demand the most precise quantitative information about obstructions and the pulmonary blood pressure. Few congenital lesions cannot at present be surgically ameliorated.

The most important and reliable information that can be obtained in complex lesions concerns pulmonary stenosis. Furthermore the anatomical type can be indicated with some success. The localization of either dominantly left-to-right or bidirectional shunts can be accomplished. The presence of abnormal sites of entry of pulmonary veins and occasionally unusual systemic venous drainage can be indicated. Overriding or transposition of the aorta can be strongly suggested by the catheter easily entering the aorta from the right ventricle, but in complicated transposition or truncus complexes, catheterization is usually more of an adjunct to angiocardiology. It is, of course, of no value in lesions such as aortic coarctation which are not characteristically reflected in the right heart chambers. Except when atypical or pulmonary hypertension is suspected, the patent ductus is also not often catheterized.

Catheterization has a limited but useful place in acquired heart disease. The contour of the auricular pressure recordings indicates, among other things, the functional state of the tricuspid valve. In an occasional case of rheumatic mitral disease, it is helpful to know the exact level of pulmonary blood pressure. Constrictive pericarditis alters the pressure volume relationship of the right ventricle: a fairly characteristic abrupt pressure rise occurs as diastolic inflow begins. The same dynamics may also occur with amyloid infiltration of the myocardium and "constrictive endocarditis". Acquired defects of the interventricular septum may be diagnosed, and at least one has been successfully repaired. The dramatic rupture of aortic sinus aneurysms or of the diseased aorta into right heart chambers can also be confirmed.

The overall mortality is surprisingly low in view of the frequency of startling but transient arrhythmias when the catheter tip is tickling the ventricular septum. It probably does not exceed one or two per thousand in experienced hands. Among the deaths, a formidable number have been cases of Ebstein's disease or primary pulmonary hypertension. Small children, particularly if cyanotic, carry the added risk of an anesthetic. Auricular fibrillation and moderate congestive failure are not contraindications.

Medical College of Georgia

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association

THE ASSOCIATION

Council of the MAG

January 27, 1957, Macon

CHAIRMAN J. W. CHAMBERS, LaGrange, called the special meeting of the Council of the Medical Association of Georgia to order at 10:15 a.m., Dempsey Hotel, Macon, January 27, 1957.

Officers and councilors present included: Hal M. Davison, Atlanta, President; W. Bruce Schaefer, Toccoa, President-Elect; H. Dawson Allen, Milledgeville, Immediate Past President; Thomas W. Goodwin, Augusta, House of Delegates Speaker; Lee Howard, Sr., Savannah, 1st District Councilor; George R. Dillinger, Thomasville, 2nd District Councilor; W. G. Elliott, Cuthbert, 3rd District Councilor; J. W. Chambers, LaGrange, 4th District Councilor; J. G. McDaniel, Atlanta, 5th District Councilor; Henry H. Tift, Macon, 6th District Councilor; D. Lloyd Wood, Dalton, 7th District Councilor; F. G. Eldridge, Valdosta, 8th District Councilor; Charles R. Andrews, Canton, 9th District Councilor; and, H. L. Cheves, Union Point, 10th District Councilor.

Vice-Councilors present included J. Z. McDaniel, Albany, 2nd District; George H. Alexander, Forsyth, 6th District; and J. Victor Roule, Augusta, 10th District. Association AMA Delegates present included C. H. Richardson, Sr., Macon, and Eustace A. Allen, Atlanta. Also in attendance was Edgar Woody, Jr., Editor, *Journal of the Medical Association of Georgia*. Special Legal Counsel, Mr. Francis Shackelford, Atlanta, was present. Messrs. Milton D. Krueger and John F. Kiser of the Headquarters Office Staff were also present. Guests of the Council included Charles W. Hock, Augusta, President, Richmond County Medical Society; Virgil P. Sydenstricker, Augusta, and David R. Thomas, Jr., Augusta.

REVIEW OF MINUTES—December 15-16, 1956 Council meeting; Executive Committee of Council action of January 8, 1957 (Attorney authorization for Richmond County Medical Society meeting); and Executive Committee of Council action of January 23, 1957 (MAG Legislative policy). Mr. Krueger summarized minutes of the December 15-16, 1956, meeting of Council. Mr. Krueger stated that (1) the Executive Committee of Council phone call vote on January 8, 1957, approved a request from the Richmond County Medical Society Board of Governors for Special Attorney Mr. Francis Shackelford to attend the Richmond County Medical Society January 22, 1957, meeting, and made two recommendations: (a) that the announcement be made at the meeting that Mr. Shackelford's attendance was authorized by the Executive Committee at the request of the Richmond County Medical Society Board of Governors; (b) that a copy of the Executive Committee's authorization for Mr. Shackelford's attendance be sent to Edgar Pund, President of the Medical College of Georgia.

(2) Executive Committee of Council voted in a conference phone call on January 23, 1957, to ask the Legislative Committee to actively oppose House Bill 107 (an act to amend Section 84-1209 of the Code of Georgia, 1933, defining the practice of Osteopathy).

RICHMOND COUNTY MEDICAL SOCIETY "DECEMBER 11, 1956 RESOLUTION" AND THE RCMS JANUARY 22, 1957 "WATERS RESOLUTION"—Charles W. Hock, President of the Richmond County Medical Society, read the official minutes of his society's January 22, 1957, meeting and the "Waters Resolution," which follows, presented at that meeting.

"WATERS RESOLUTION" BY THE RICHMOND COUNTY MEDICAL SOCIETY

January 22, 1957

Concerning the Operational Policies of the Eugene Talmadge Memorial Hospital

PUBLIC RELATIONS: All public relations by the Eugene Talmadge Memorial Hospital and the Medical College of Georgia shall be cleared through the Public Relations Committee of the Richmond County Medical Society. This shall conform with the Code of Ethics of the American Medical Association.

LIAISON COMMITTEE: A liaison committee shall be appointed to consist of five members from the Richmond County Medical Society, two members from the Council of the Medical Association of Georgia, the President of the Medical College of Georgia, and the Director of the Eugene Talmadge Memorial Hospital. This committee shall be empowered to meet at appropriate intervals to investigate and to act on problems which arise between private practitioners, patients, and these institutions. Any complaints or other problems shall be referred to this committee in writing. The committee will make its report to the Richmond County Medical Society at appropriate intervals. The president of the Richmond County Medical Society shall appoint the five members from this society. The president of the Medical Association of Georgia shall appoint the two members from the Council of the Medical Association of Georgia.

ADMISSIONS: It is not and shall not become the policy of the Medical College of Georgia and the Talmadge Memorial Hospital to enter into the competitive practice of medicine. Insofar as patient care is concerned, it is the purpose of these institutions, first and foremost, to care for the medically indigent of this state. Admissions of patients of unusual teaching interests shall be favored. It is realized, however, that dire emergencies and unusual circumstances will arise in which patients who are not so indigent will require the services of these institutions. No other pay (private) patients shall be admitted. This policy shall apply to both in and out patients.

The term "unusual circumstances" shall be understood to apply to those patients whose problems cannot be properly cared for through the usual private practice channels in this area. Any question or controversy arising will be referred to the liaison committee in writing for the committee's consideration.

No patient may be accepted by either institution except by proper referral of the *regular attending physician*.

Pay (private) patients admitted under the category of dire emergencies should be transferred from the Eugene Talmadge Memorial Hospital when and if their condition permits.

FEES: Patients coming under the categories of dire emergencies and unusual circumstances who are financially able to pay shall be rendered a hospital bill commensurate with the hospital charges in this area. No bill shall be rendered for the professional services; however, the patient may be invited to contribute to the Research Fund. These contributions should be made payable to the Research Fund of the Medical College of Georgia. Use of the funds so obtained shall be for medical research purposes as recommended by a faculty committee established for this purpose. The system of collection and use of such funds shall be within the limitations of the Code of Ethics of the American Medical Association.

CLINICAL FACULTY: It is the desire of the Medical College of Georgia and the Richmond County Medical Society to develop a strong and excellently qualified clinical faculty. Every rightful effort shall be made to develop an atmosphere in this area which will entice and keep men of such desirable qualifications.

PURPOSE: This resolution is made in the sincere desire to maintain and develop the highest quality of medical teaching and medical care for the people of this area. This proposal is considered by the Richmond County Medical Society to be ethical and legal and all of those participating in such a program will be considered to be ethical practitioners of medicine and eligible for membership in the Richmond County Medical Society insofar as this problem is concerned.

This resolution supersedes all previous resolutions concerning the operational policies of the Eugene Talmadge Memorial Hospital.

Dr. Hock, per the minutes of the meeting, informed councilors that a vote was taken on the "Waters Resolution" by the society as a whole by secret ballot and the official vote was 85 for the resolution and 23 against the resolution, so the resolution carried. It was further explained that as the last paragraph of the "Waters Resolution" provides that this resolution shall supersede all previous resolutions, the "Waters Resolution" should be considered in place of the "Richmond County Medical Society December 11 Resolution" which specifically requested Council approval; the chairman so ruled.

The chairman called for discussion and recognized Thomas W. Goodwin, Augusta, who introduced Virgil P. Sydenstricker, who informed the Council that the faculty of the Medical College of Georgia had met twice since the January 22, 1957, meeting and wished to present to the Council a resolution adopted by them on January 25, 1957, which is as follows:

"FACULTY RESOLUTION"

January 25, 1957

In view of the recent action taken by the Richmond County Medical Society, the active staff of the Eugene Talmadge Memorial Hospital of the Medical College of Georgia deems it wise to reaffirm its belief that the operational policies adopted by the Board of Regents on March 9th, 1955, should be continued.

These policies, regulated by laws of Georgia and duly authorized by the Board of Regents, do conform with the principles of ethics for private prac-

tices by medical school faculty members as recommended by the House of Delegates of the AMA in June 1956.

The primary purposes of the Medical College of Georgia and the Eugene Talmadge Memorial Hospital are to establish a medical center leading to optimum development of undergraduate, graduate, and postgraduate education; to promote research designed to increase medical knowledge; and to provide those medical services to the people and physicians of Georgia which are necessary to accomplish the above overall aims, but in a manner which will not take the form of competitive private practice.

The teaching of modern medicine on undergraduate, resident and postgraduate levels would be considerably less effective if the number and variety of patients were to be confined to the medically indigent. Determination of the availability of medical care for each geographic area of the state is beyond the resources and power of the hospital administration and staff, and it should be the obligation of the patient's physician to make this decision. The staff wishes to reaffirm the right of the patient's physician to make whatever decision he deems necessary in the best interest of the patient, and in addition, the right of the patient to choose his own physician.

Patients able to pay in whole or in part for their professional care should be required to do so whenever and wherever such service may be rendered. Failure to do so would constitute socialized medicine. Professional charges should conform to prevailing rates.

It is recognized that continued differences between organized medicine as represented by Richmond County Medical Society and the Board of Regents with reference to operational policies represents a detrimental influence on medical education, research, and proper medical care. This controversy should be resolved.

Attachments: Resolution by Richmond County Medical Society January 22, 1957; Resolution by the Board of Regents of the University System of Georgia, March 9, 1955; Committee report adopted by Eugene Talmadge Memorial Hospital Staff, January 5, 1957.

Dr. Goodwin commented on the differences between the Board of Regents policies and the "Waters Resolution." He then introduced the "Goodwin Resolution" which follows:

"GOODWIN RESOLUTION"

It is moved that the Council of the Medical Association of Georgia appoint a special committee of its own members to handle this problem, make appropriate investigations, and report back to Council at its next regular meeting. This committee is to gather all facts and arguments on both sides and, among other things, it is requested to specifically do the following:

1. Contact the legal department of the American Medical Association for an opinion as to whether or not the present operational plan constitutes the corporate practice of medicine and whether or not, in their opinion, it is legal.

2. Contact the Committee on Ethics of the American Medical Association for an opinion as to whether

or not the plan falls within the framework of the Code of Ethics of the American Medical Association.

3. Contact the Judicial Committee of the American Medical Association in regard as to whether or not the Richmond County Medical Society is justified in its present stand in regard to the admission of faculty members.

4. Instruct Mr. Shackelford to go to Augusta and confer with the authorities of the Medical School and Hospital in regard to the details of administration and policies now in force in order to be thoroughly familiar with them before rendering his final opinion. The committee might consider the advisability of making such a visit themselves.

5. Instruct Mr. Shackelford to contact the attorneys of the Board of Regents and the Attorney General's office in order to discuss the legal problems involved with them. The committee might well desire to take part in these discussions, also, and might desire to contact the Board of Regents themselves in order to obtain their cooperation in the furtherance of these discussions.

6. Request the Board of Regents to have one of its legal representatives at the next meeting of Council with a brief of the Board of Regents' position as to the legality of the plan in order that both sides may be heard from on this score.

7. Assure the Medical College of Georgia and the Richmond County Medical Society that Council is taking its obligation in this matter seriously and inform them of the steps that are being taken in order to settle this matter once and for all. Both parties are urged to exercise patience and restraint until this matter can be cleared up.

The Chairman called on Mr. Francis Shackelford, MAG Attorney, for his opinion on these matters, and he said that progress has been made and gap of differences has been narrowed. He pointed out that the problem in his viewpoint was similar to a three-legged stool: the Richmond County Medical Society, the Talmadge Memorial Hospital, and the Medical College each being one of the prime supports necessary for a firm foundation. Mr. Shackelford cited Georgia cases and cases in other states in which either a profit or non-profit corporation has been restrained from collecting fees. He did state further that some states would allow this practice. He then suggested that certain Medical Association of Georgia and Richmond County Medical Society officials confer in the near future with the Chairman of the Board of Regents.

Chairman Chambers said that, in his opinion, the Association Council and House of Delegates are not concerned with the admission of pay patients and further that the Association has no desire to dictate administrative policies. However, Dr. Chambers stated the Association is concerned with these policies if they violate the Association's and the AMA's Code of Ethics, and further, that if the authorities choose to admit pay patients, they must conform to the Association and AMA Ethics in the way that fees shall be collected.

A motion to table the "Goodwin Resolution" was approved. (Privileged motion not discussed.)

The "Waters Resolution" was the next order of business and there was discussion of the ethics and legality of it. Mr. Shackelford's opinion was that the policy prescribed in the "Waters Resolution" was legal.

It was moved that the Council approve the "Waters Resolution." President Davison then expressed his viewpoint that the Association does not have the right to tell the Medical College of Georgia specifically how to administer policy in the Talmadge Hospital, but that the Association should state what is within the ethics of the profession.

Dr. Davison introduced a substitute motion for the above motion (approval of the "Waters Resolution") which was as follows: That the "Waters Resolution" comes within the Medical Association of Georgia Council conception of being legal and ethical. This motion was seconded by Dr. Elliott and after discussion, the motion was approved. (Substitute motion passed—no action required on original.)

Dr. Davison moved that the chairman of the Council of the Medical Association of Georgia appoint a five-man committee, with the president and chairman of Council as additional members, to recommend to the Council what should be considered ethical and legal by the Medical Association of Georgia for teaching institutions and hospitals and report with this recommendation to the March MAG Council meeting. Motion was approved.

Chairman Chambers recessed the meeting for luncheon.

Chairman Chambers recalled the Council of the Medical Association of Georgia meeting to order at 2:45 p.m., January 27, 1957.

EMORY MEDICAL SCHOOL LIAISON—Chairman Chambers called on MAG Attorney Francis Shackelford to report on the progress of the Emory University School of Medicine investigation. Mr. Shackelford stated that a number of informal meetings with the attorneys representing Emory have been held and a formal meeting of the MAG Medical Education Subcommittee for Liaison with Emory University School of Medicine had also been held. He pointed out that the problem is seemingly one of contractual arrangements between the Emory University Clinic and the physicians, and that publicity practices also might pose a problem therein. Mr. Shackelford said there would be further meetings on these problems and he would so report at a later date.

HOSPITAL RELATIONS COMMITTEE APPOINTMENT—Mr. Krueger read a letter from Albert M. Deal, member of the MAG-Hospital Relations Committee, dated December 26, 1956, in which Dr. Deal requested that he be allowed to resign from the committee. Dr. Deal recommended that L. H. Griffin of Claxton be appointed to serve in his place. On motion the Executive Committee of Council appointed Dr. Griffin to replace Dr. Deal on this committee.

STATE MEDICAL EDUCATION BOARD—By general agreement, it was recommended that the president of the Georgia Academy of General Practice be asked to submit to the Executive Committee of Council for approval nominations for membership on the State Medical Education Board.

ANNUAL SESSION EQUIPMENT—J. G. McDaniel presented a recommendation to the Council Committee on Annual Session received from Ted F. Leigh, Chairman of the Committee on Scientific Exhibits and Awards, that the Association purchase "view-boxes" to use at annual sessions and other meetings.

It was moved that the Association purchase two view-boxes at \$495.00 each, if funds were available, and that the Chairman of the Finance Committee report on the availability of funds at the February meeting of the Executive Committee of Council. After discussion, the motion was approved.

COBB COUNTY SOCIETY RESOLUTION—A resolution by the Cobb County Medical Society which concerned the enforcement of pharmacy laws in Georgia was presented to the Council of the Association for action. Mr. Krueger brought to the attention of Council the fact that the Newton County Medical Society had made a similar resolution which was approved at the December 15-16, 1956 MAG Council meeting. It was moved that the Cobb County Medical Society resolution be approved and that action be taken on it similar to that on the Newton County Medical Society resolution. Motion approved.

HEADQUARTERS OFFICE REPORT—

(1) Medicare Administration—Mr. Dougald Avera has been employed as administrator of the Dependents' Medical Care Act. Mr. Krueger noted there was controversy with the Government concerning expenses incurred by the Review Board and Legal Counsel in administering the program. Mr. Avera will need an assistant within the month and the Review Board will be convened January 29 to facilitate the administration of the program. The following resolution was approved.

“RESOLVED, that Dr. J. W. Chambers, Chairman of Council, and Dr. Hal M. Davison, President of the Medical Association of Georgia, be and they are hereby authorized to execute on behalf of the Medical Association of Georgia an amendment to Contract No. DA-49-007-MD-812 of 30 November 1956, said amendment being entitled “Supplemental Agreement re: Advance Payments under Two Party Contracts (30 Nov. 56)” and providing for advance payments by the United States Government under the medicare program, PL 569 of 1956, and whereby the Medical Association of Georgia agrees to be obligated on a bond and to account for, receive and return monies in accordance with the contract, said amendment and directions by the Contracting Officer, and further to execute such other contracts and bonds as are required by said contracts as amended.

BE IT FURTHER RESOLVED, that Dr. David Henry Poer be and he is hereby authorized to sign on behalf of the Medical Association of Georgia the periodic form, each time when due, required by the United States Government before each advance payment entitled “Public Voucher for Purchases and Services other than Personal,” Standard Form No. 1034.

BE IT FURTHER RESOLVED, that Council, already having delegated to the Executive Committee of Council the administration of the Medicare Program as Fiscal Agent, authorizes and empowers said Executive Committee, its delegate or delegates, to take all of the necessary actions and execute all of the required papers in connection with the administration of said contract, as amended.”

(2) Mental Health—The Governor of Georgia acknowledged receipt of a copy of a resolution adopted by the Association relative to the establishment of a study committee on mental health.

(3) Legislation—Mr. Kiser discussed bills of medical interest before the General Assembly.

(4) Eyecare of the Newborn—It was brought to the attention of Council that Dr. Davison had been asked by the Director of the Division of Maternal and Child Health, State of Georgia Department of Public Health, to appoint a committee for “Eyecare of the Newborn.” Council approved the formation of a special committee of the Association to be appointed by the President.

(5) Employees' Privileges—Mr. Krueger requested clarification concerning MAG employees' privileges that had been adopted at the December 15-16, 1956, meeting of the Council. These clarifications were as follows:

Sick Leave—That an employee be retained on the payroll for the following prescribed period in the event of actual sickness or accident and that any absence due to actual disease or accident extending beyond the above limitations would be considered absence without pay at the discretion of the Executive Committee: At any time during first year of employment—one week sick leave. At any time during second year of employment—two weeks sick leave. At any time during fifth year of employment—three weeks sick leave.

Vacations—That each employee be allowed the following annual vacation with pay. During the first year of employment, after six months of service—one week's vacation; any time during the second year of employment and thereafter—two weeks' vacation; any time during the fifth year of employment and thereafter—three weeks' vacation.

Christmas Bonus—That each employee receive an annual bonus at Christmastime, if that employee is on the Association payroll as of December 25, and at no time during the year should employee receive additional bonus, and the amount of this Christmas bonus to be set as follows: After completion of first year of employment—one-quarter month's pay. After completion of second year of employment—one-half month's pay. After completion of fifth year of employment—three-quarters month's pay. After completion of tenth year of employment—one month's pay. The motion further stated that any term of employment within weeks of December 25 would be handled as an individual case by the Executive Committee of Council so that an employee might not be penalized. The motion further stated that for the basis of computing the amount of these bonuses an employee's salary would be considered to be both the remuneration received from the Georgia Academy of General Practice and the salary of the Medical Association of Georgia. The GP remuneration was believed to be part of salary as the arrangement between the Association and the General Practitioners is at the discretion of the Council. This motion was then approved.

MAG JOURNAL ADVERTISING POLICY—Edgar Woody, Jr., Editor of the *Journal of the Medical Association of Georgia*, brought to the attention of the members of Council an application from Charles C. Haskell & Company, Inc., to advertise in the *Journal*. It was approved that this firm be allowed to advertise in the *Association Journal*.

MARCH COUNCIL MEETING DATE—By general agreement of Council, March 9-10, 1957, was set as the date of the March Council meeting to be held on the

invitation of the Dougherty County Medical Society at Radium Springs, Georgia.

EXECUTIVE COMMITTEE MEETING DATE—

By general agreement of the Executive Committee, February 15 or 16 was selected as the meeting date for the regular February meeting of the Executive Committee of Council and the site chosen for this meeting was Atlanta.

Chairman Chambers raised the question of sending information to the membership on the background and present status of the controversy concerning the operational policies of the Eugene Talmadge Memorial Hospital. By general agreement this item of business was put on the agenda for the March Council meeting.

The meeting was adjourned at 4:35 p.m.

Executive Committee of Council

February 16, 1957, Atlanta

GEORGE R. DILLINGER, Thomasville, Vice-Chairman of Council, now Acting Chairman of Council due to the illness of the Chairman, called the meeting of the Executive Committee of Council to order at 7:30 p.m.

Members present included: George R. Dillinger, Thomasville; Hal M. Davison, Atlanta, President; and David Henry Poer, Atlanta, Secretary. Also in attendance was Mr. M. D. Krueger, Atlanta, Executive Secretary.

Quorum—Chairman Dillinger declared a quorum of the Executive Committee present according to Robert's *Rules of Order*. It was moved that it be recommended to the Association Constitution and By-Laws Committee that Chapter IV, Section 3, *Executive Committee*, should be changed to read: "That three (3) members of the Executive Committee constitute a quorum of said committee for any meeting that has been duly called after all members have been notified of this call in advance of the meeting." Motion approved.

Finance Committee of Council—Dr. Dillinger submitted his resignation as Chairman of the Council Finance Committee; he will remain a member of the committee. Dr. Dillinger, as Chairman of Council, appointed J. G. McDaniel, Atlanta, Chairman of the Finance Committee. This action was approved.

Monthly Budget Report—Dr. Dillinger discussed the monthly budget report compiled by the Headquarters Office, and it was approved that the January 1957 long distance phone and telegraph bill be charged to the Legislative Committee. Postage disbursements for the month of January were approved.

Cornell University Medical College Automotive Crash Injury Research—Mr. Krueger presented a letter from Myron I. Macht, Assistant Supervisor, Field Operations of the Cornell University Medical College, which requested approval of the Medical Association of Georgia of a program of automotive crash injury research to be carried on in Georgia for the establishment of a Georgia-Cornell Automotive Crash Injury Research Study and an Atlanta-Cornell Automotive Crash Injury Research Study in conjunction with the Georgia State Patrol, the Georgia Department of Health, the City of Atlanta Police Department and the Fulton County Health Department. It was moved that the Association endorse such studies and that the Executive Committee of Council refer this information to the Association's Public Service Committee asking them to cooperate in this project. Motion approved.

Fluoridation—Correspondence from Benjamin Spock, Chairman of the "Committee to Protect our Children's Teeth, Inc." (New York City) was read. This correspondence requested that the Medical Association of Georgia inform the Mayor of New York of its policy on fluoridation. It was moved that Mr. Krueger inform Mayor Robert F. Wagner, Jr., New York City, of the MAG House of Delegate's action on fluoridation. Motion approved.

Medical Defense—Correspondence from Mr. John A. Dunaway concerning the defense of a member of the Medical Association of Georgia was presented. It was moved that because Mr. Dunaway and the physician were both aware of the action the House of Delegates took at the 106th Annual Session, May 15, 1956, changing the present Constitution and By-Laws concerning Medical Defense, that the Association is bound under that Constitution and By-Laws to remit as follows: "The Committee (Medical Defense) shall on the advice of Council, in cases being worthy of defense, furnish the services of the Association counsel for the purpose of consultation and advice relative to threatened or actual litigation provided the Association does not assume financial obligation in excess of \$100.00 for any one member in any one calendar year. Any fees or charges in excess of \$100.00 for any one member in any one calendar year shall be borne by the member so requesting the privilege of medical defense, consultation and advice as stated herein." Mr. Krueger was instructed to render payment in the amount of \$100.00 to the Association Attorney for this service and notify all others concerned that the Association could assume no more responsibility. Motion approved.

Hospital Care Study Commission—Mr. Krueger informed the Executive Committee, per a January 15, 1957, letter from Helen W. Bellhouse, of expenses in connection with the printing of a short form for the Hospital Care Study Commission. The expense incurred was \$213.50 and Dr. Bellhouse requested that the Association pay half this charge: \$106.75. It was explained that although the Association had appropriated \$300.00 for the use of the Hospital Care Study Commission in 1956, no 1957 appropriation was made. It was moved that the Association approve \$106.75 to pay one-half of this bill as requested by Dr. Bellhouse, and that this expense be charged to the Hospital Relations Committee. Motion approved.

Peach Belt Medical Society Ethics Problem—The conduct of two physicians in the Peach Belt County Medical Society was discussed, and it was moved that Mr. Krueger be instructed to write the Secretary of the Peach Belt Medical Society requesting the results of action taken by that society's Grievance Committee in this case, and that if no action has been taken by the Peach Belt Medical Society, that the president and secretary of the society and the two physicians involved in this matter be requested to appear at the March 9-10 MAG Council meeting to discuss the matter further with the members of Council. Motion approved.

Annual Session View Boxes—George R. Dillinger, as requested at the last (January 27, 1957) MAG Council meeting reported that funds were not available at the present time for the purchase of two view boxes costing a total of \$1,000. It was recommended that this item be reviewed by the incoming Council at the time of the Annual Session or as soon thereafter as possible.



physician's bookshelf

Reviews

Goldman, Mervin J., M.D., **PRINCIPLES OF CLINICAL ELECTROCARDIOGRAPHY**, Lange Medical Publications, Los Altos, Calif., 1956, 310 pp., \$4.50.

Innumerable books of "clinical electrocardiography" now exist. Almost all, including this one, adequately illustrate the well recognized diagnostic patterns. The approach to fundamentals, however, varies widely according to the knowledge, background, aims, and bias of the authors. This book is an ordinary member of the family, neither the best nor the worst of its breed. The cost, reproductions, indexing, and sometimes ingenious diagrams commend it. Binding (paper) is adequate in view of price. Treatment of exercise tests and infarctions is well considered. The final section of test tracings is good. The problem is to find an appropriate audience for the book. The semi-experienced will find little new, and one would recommend it to the tyro with misgivings for several reasons. Inevitably a reviewer's own prejudices will creep into such a criticism, but the chapters on the genesis of the normal electrocardiogram are not satisfying. The concept of three-dimensional sampling of the electrical field around the heart is underemphasized, as is what logically follows, the two distinct planes in which the three common lead systems are recorded. The vector concept is briefly examined, but since it is never utilized, the space is largely wasted; as a matter of fact, unnecessary empiricism is often the only "explanation." To the somewhat more experienced, many distressing omissions or near-omissions will be apparent. The concepts of ventricular overloading, special uses in congenital heart disease, and the implications of childhood and operating room tracings are largely lacking. The electrolyte section is skimpy. Only 10 general references (six by Prinzmetal) are listed.

Impression: Satisfactory textbook for the author's courses.

Prognosis: One edition.

A. Calhoun Witham, M.D.

Lipman, Bernard S., M.D., and Massie, Edward, M.D., **CLINICAL UNIPOLAR ELECTROCARDIOGRAPHY**, The Year Book Publishers, Inc., Chicago, 1956, 393 pp., 325 illustrations, \$7.50.

This book, first published in 1951, was reprinted in 1952. The edition of 1953 was reprinted in 1954 and 1955. This new third edition entitles it to recognition as a classic. The secret of its continued success lies in the simplicity of approach, the clarity of expression, and the excellence of its diagrams, not to mention the atlas of 1955 electrocardiograms at the end. Georgia

may well be proud that its senior author has for six years been one of its hardworking citizens.

This 1956 edition is much more than a reprint of its predecessors. Since 1953 the progress of cardiology and the accompanying advances in electrocardiography have made a new book necessary.

Congenital heart disease, not so long ago an esoteric subject considered of only academic interest "because you can't do anything about it," has become one of the hottest fields in medicine. No parents today would be content with a simple diagnosis of congenital heart disease: they know that many of these anomalies can be corrected surgically, and they want to know if their child's lesion falls in such a category. Acquired valvular disease has also been brought into the realm of surgery. In such cases now the desideratum is to select for operation those patients who are moderately handicapped and who are apt to become increasingly disabled, ruling out those whose symptoms do not justify surgery on one hand, though the risk of operation is minimal, and on the other those who stand little chance of much benefit in the event they survive operation. The electrocardiogram can be of some help in the selection of cases for operation.

In addition to a good discussion of the above, the new edition has been expanded to include the arrhythmias, ventricular gradient, vector-cardiography and vector electrocardiography. It is thus modernized and rendered more complete.

Written primarily for the beginner in electrocardiography, rare is the man who cannot profit from a careful study of the new edition, even if much proves only to refresh his memory. Lest this reviewer appear unduly prejudiced on the subject, it must be admitted that at times the text verges on dogmatism, but this has the advantage of keeping it within reasonable limits.

In passing it may be remarked that in September, 1955, I was host to a young cardiologist from Jerusalem; the visitor noted the Lipman volume on the desk and when he learned that the senior author was a local man, his opinion of Georgia medicine was heightened; he was sure it was the best book on the subject ever published, as was his more experienced father.

Clinical Unipolar Electrocardiography repeatedly emphasizes that the electrocardiogram alone does not provide sufficient data for a complete diagnosis and evaluation of any patient. The book is recommended wholeheartedly to all who are interested in the study of the heart.

L. Minor Blackford, M.D.

Executive Committee (cont'd)

Corporate Practice of Medicine—Dr. Davison reported on the progress of discussions with Emory University School of Medicine and the areas of agreement and disagreement. There was also discussion of the Medical College of Georgia and the Eugene Talmdage Memorial Hospital problem in connection with the cor-

porate practice of medicine. No action was taken on this matter as it was recommended and approved that this information be given to the Special Committee of Council on Medical School Ethics designed to handle this matter.

The meeting was adjourned at 10:30 p.m.

ANNOUNCEMENTS

Meeting Calendar

American Medical Association—June 3-7, 1957, The Coliseum, New York City.

American College of Physicians—April 8-12, 1957, Boston, Mass.

American College of Surgeons Regional Meeting—February 4-7, 1957, Roosevelt Hotel, New Orleans, La.

Medical Association of Georgia—April 28-May 1, 1957, DeSoto Hotel, Savannah.

Georgia Society of Anesthesiologists—April 28, 29, 1957, Savannah.

Georgia Diabetes Association—April 28-May 1, 1957, DeSoto Hotel, Savannah.

Georgia Society of Ophthalmology and Otolaryngology—May 18-23, 1957, aboard S. S. Silverstar from Charleston, S. C.

Georgia Psychiatric Association—February 18, 1957, Atlanta.

Georgia Urological Association—April 28-May 1, 1957, DeSoto Hotel, Savannah.

Georgia Industrial Surgeons Association—April 28-May 1, 1957, DeSoto Hotel, Savannah.

Two-Day Course in Electrolytes—March 29 and 30, 1957, Emory University School of Medicine, Emory University, Ga. Course will be under the direction of Arthur Merrill, associate professor of medicine, and other faculty members of Emory University. Visiting faculty includes Ted S. Danowski, professor of research medicine, University of Pittsburgh, and Louis G. Welt, professor of medicine, University of North Carolina. For further information, address Postgraduate Teaching Program, Emory University School of Medicine, Atlanta, Ga.

Clinical Workshop in Treating Circulatory Disorders—March 28-30, 1957, Medical College of Georgia, Augusta, Ga. This intensive postgraduate session will emphasize the capacity of drugs and other therapeutic agents to modify diseases of the circulation. Registrants will work closely with patients selected to illustrate the therapeutic problems under consideration. Faculty participating in the course include both visiting and Medical College of Georgia physicians.

C. Thorpe Ray, associate professor of medicine at Tulane University School of Medicine, will be featured as will Thomas Findley, A. C. Witham, Herbert Schaefer, and R. P. Ahlquist, all of the Medical College of Georgia. A fee of \$25.00 will be charged for the session; registration is limited to 20 physicians. Application, accompanied by a check made payable to the Medical College of Georgia, should be made as soon as possible to: Dr. Virgil P. Sydenstricker, Dean, Postgraduate Education, Medical College of Georgia, Augusta, Ga.

Annual Prize Lecture, American Congress of Physical Medicine and Rehabilitation—Manuscripts must be submitted by June 1, 1957. Contest open to medical students, interns, residents, graduate students in the pre-clinical sciences, and graduate students in physical medicine and rehabilitation. For information write to the American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Ave., Chicago 2, Ill.

American Congress of Physical Medicine and Rehabilitation—35th annual scientific and clinical session, September 8-13, 1957, Hotel Statler, Los Angeles, Calif. For information, write to the Executive Secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Ave., Chicago 2, Ill.

American College of Physicians 1957 Annual Session—April 8-12, 1957, Boston. For information write to Dr. Richard P. Stetson, 203 Commonwealth Ave., Boston 16, Mass.

Seminar on Kidney Diseases—May 10, 1957, Academy of Medicine, 875 W. Peachtree St. N.E., Atlanta, Ga. Arthur C. Allen, M.D., Associate Pathologist Memorial Center for Cancer and Allied Diseases, New York City, will moderate a seminar on Kidney Diseases from 8:45 to 11:00 a.m. on May 10 in the auditorium of the Academy of Medicine. Immediately following, Dr. Allen will deliver a lecture entitled "The Clinico-Pathologic Meaning of the Nephrotic Syndrome." All physicians are invited to attend the seminar as well as the lecture. This program is sponsored by the Atlanta Pathology Seminar Group and the Georgia Division of the American

Cancer Society. This is the first of a series of annual seminars planned by the Atlanta Pathology Group.

4th International Poliomyelitis Conference—July 8-12, 1957, Geneva, Switzerland. For information, write to the Secretariat of the Fourth International Poliomyelitis Conference, Hotel du Rhone, Geneva, Switzerland. Telegraphic address: Inpolio, Geneva.

Federal Civil Defense Administration Staff College Health Services Course No. Two—April 15-19, 1957, Academy of Medicine, 875 West Peachtree St. N.E., Atlanta, Ga. Registration for the Staff College is limited to 200 and will include besides doctors of medicine, dentists, nurses, hospital administrators, veterinarians, and other paramedical personnel interested in civil defense. Registrations will be handled by Dr. Lester Petrie, Deputy Director, Georgia Civil Defense Health Service, Dept. of Public Health, Atlanta, Ga. Immediately following this course, the *Implementation Committee of the Health Services, FDCA Region Three*, will meet from noon April 19 to noon April 20 at the VA Hospital, No. 48, 5998 Peachtree Rd. N.E., Atlanta.

Georgia Society of Ophthalmology and Otolaryngology Annual Meeting—March 21-23, 1957, General Oglethorpe Hotel, Savannah, Ga. (instead of on shipboard cruise). Speakers include Daniel C. Baker, Professor of Otolaryngology, Presbyterian-Columbia Medical Center, New York, and Alfred E. Maumenee, Professor of Ophthalmology, Johns Hopkins Hospital, Baltimore. Registration fee: \$25.00.

Refresher Courses offered by The Children's Hospital of Philadelphia—(1) *Pediatric Advance for Pediatricians and General Practitioners*—May 27-31, 1957, conducted by the staff of the Children's Hospital of Philadelphia in collaboration with the Dept. of Pediatrics of the Univ. of Pa. and the staff of the Camden Municipal Hospital. Tuition: \$110. (2) *Practical Pediatric Hematology*—June 3-5, 1957. Conducted by Irving J. Wolman, M.D., and other members of the Hematology Dept. under the auspices of the Graduate School of Medicine, Univ. of Pa., Tuition: \$75.00. (3) *Blood Group Incompatibilities and Erythroblastosis Fetalis*—June 6 and 7, 1957. Conducted by Neva Abelson, M.D.,

(Announcements)

and Thomas R. Boggs, Jr., M.D., of the Philadelphia Serum Exchange of the Children's Hospital of Philadelphia, under the auspices of the Graduate School of Medicine, Univ. of Pa. Tuition: \$50.00. Inquiries should be addressed to Irving J. Wolman, M.D., Children's Hospital of Philadelphia, 1740 Bainbridge St., Philadelphia 46, Pa.

4th Interim Congress of the Pan American Association of Ophthalmology—April 7-10, 1947, Hotel Statler, New York City. Meeting is held in Joint session with the National Society for the Prevention of Blindness. Subjects for panel discussion will be "Diseases of the Ocular Fundus," "Ophthalmic Surgery," and "Therapeutics in Present-Day Ophthalmology." There will also be papers, clinics, and films for those attending, and entertainment for physicians and their wives. For information, write to Pan American Association of Ophthalmology, Frank H. Constantine, M.D., 30 West 59th St., New York 19, N. Y.

Review Course in Cardiology for Physicians and Internists—May 6-24, 1957, New York University, New York City. Course will include an intensive review of the basic knowledge and the recent advances in the diagnosis and treatment of heart disease. Electrocardiography is an integral part of the course, and emphasis is to be placed on the modern electrophysiology of the heart. For details write: The Dean, Post-Graduate Medical School, 550 First Ave., New York 16, N. Y.

8th Annual Symposium on Recent Advances in the Study of Venereal Diseases—April 24-25, 1957, Dept. of Health, Education, and Welfare, Washington, D. C. Sessions open to all physicians and workers in allied professions. Topics to be discussed will cover many aspects of venereal disease control including basic and clinical research, serology, epidemiology, treatment, program operation, and professional education. For further information, write to the Public Health Service, U. S. Dept. of Health, Education, and Welfare, Washington 25, D. C.

World Congress of Gastroenterology—May 25-31, 1957, Sheraton Park Hotel, Washington, D. C. All physicians interested in gastroenter-

ology are cordially invited to attend. Major subjects to be considered at the scientific session are Peptic Ulcer, Malabsorption and Sprue-like Syndromes, Nutrition and Its Effect on the Liver and Pancreas, Intestinal Infection and Infestation, and Cancer of the Stomach. All inquiries regarding program, housing, etc., should be directed to H. M. Pollard, M.D., Secretary General, World Congress of Gastroenterology, University Hospital, Ann Arbor, Mich.

Course on The Management of Chronic Kidney Disease—June 24-25, 1957, New York Univ., 550 First Ave., New York 16, N. Y. Under the direction of Dr. Lawrence G. Wesson, will deal with the selection and interpretation of clinically available tests for the estimation of renal function. The advantages and disadvantages of each test will be considered.

Course on the Management of Hypertension—June 26-27, 1957, New York Univ., 550 First Ave., New York 16, N. Y. Course will be under the direction of J. Marion Bryant, M.D., and will be concerned with the presentation, with appropriate clinical demonstrations, of the following subjects: a brief summary of etiologic theories, psychological factors, the natural course, relative significance of blood pressure levels, eye grounds, cardiac silhouette, electrocardiogram, renal function, significance of obesity and arteriosclerosis, and unilateral renal disease. For further information write: Office of the Associate Dean, N. Y. Univ. Post-Graduate Medical School, 550 First Ave., New York 16, N. Y.

Post-graduate Course on Gastroenterology—May 13-15, 1957, University of Colorado School of Medicine, Denver, Colo. Co-sponsored by the American Gastroenterological Assn. There will be 28 speakers, meeting open to all physicians. For further information, write to The Office of Postgraduate Medical Education, Univ. of Colorado Medical Center, 4200 East Ninth Ave., Denver 20, Colo.

Officers, South Atlantic Association of Obstetricians and Gynecologists—Elected at a meeting held in February, the 1957 officers are as follows: president—Manly E. Hutchinson, Columbia, C. C.; vice-president—C. Hampton Mauzy, Winston-Salem, N. C.; president-elect—

Charles J. Collins, Orlando, Fla.; secretary-treasurer — W. Norman Thornton, Jr. Charlottesville, Va., and assistant secretary-treasurer — Lawrence L. Hester, Jr., Charleston, S. C. The next meeting will be held at the Hollywood Beach Hotel, Hollywood, Fla., February 1-5, 1958.

12th National Industrial Health Conference—April 20-26, 1957, Kiel Auditorium, St. Louis, Mo. Sponsored by the Industrial Medical Association, the American Industrial Hygiene Association, the American Association of Industrial Nurses, the American Conference of Governmental Industrial Hygienists, and the American Association of Industrial Dentists. Complete program may be obtained by writing E. C. Holmblad, M.D., Managing Director, Industrial Medical Association, 28 East Jackson Blvd., Chicago 4, Ill.

4th Annual Mountaintop Medical Assembly—June 20, 21, 22, 1957, Waynesville, N. C. Accredited by AAGP for 15 hours. Speakers include Ellard M. You, M.D., medicine, Baylor Univ.; Robert T. Tidrick, M.D., surgery, Univ. of Iowa; J. Willis Hurst, M.D., medicine, Emory Univ.; C. Ronald Stephen, M.D., anesthesiology, Duke Univ.; Harry R. Draper, M.D., psychiatry, Univ. of Pa.; and Lawrence L. Hester, Jr., M.D., obstetrics, Medical College of S. C. For further information write to Dr. J. Frank Hammett, Jr., Box 669, Waynesville, N. C.

DEATHS

STEVAN M. CARROLL, Marietta, was killed on January 24, 1957, when his car was struck by railroad cars being switched at a crossing in Marietta. The accident occurred at 11 o'clock at night while Dr. Carroll was returning to his home after making a house call.

A native of Birmingham, Dr. Carroll was a graduate of Emory University School of Medicine, class of 1952. He interned at Grady Hospital in Atlanta and was a member of the teaching staff at Grady and Emory. He had practiced in Marietta for the last two years in association with E. A. Vaughn and R. S. Causey and was chief of pediatrics at Kenestone Hospital in Marietta.

Dr. Carroll was a veteran of World War II and a member of the First Presbyterian Church, Hor-

(Deaths)

ace Orr Legion Post, the American Heart Association, and Cobb County Medical Society.

Survivors include his wife, the former Miss Peggy Pittard; a daughter, Miss Anne Kathleen Carroll; two sons, Stevan M. Carroll, III, and W. Carter Carroll, all of Marietta; and his parents, Mr. and Mrs. Stevan M. Carroll, Birmingham, Ala.

Funeral services were held on January 26th in Marietta with burial in Westview Cemetery in Atlanta.

ROBERT MALACHI MOORE, Atlanta, died on January 21, 1957, at the age of 93. He had been in declining health for several years, but his condition became serious only a few days before his death.

Dr. Moore was born in Cherokee County and graduated from the Georgia Eclectic Medical College in Atlanta in 1885. He practiced medicine for 68 years in Waleska and in addition was one of the county's most public spirited citizens. He was an official of Reinhardt College from its inception in 1883, he represented Cherokee County in the Georgia General Assembly from 1905 to 1908, and he was on the Cherokee County Board of Education from 1931 to 1956, serving as chairman from 1939 until his retirement. He also served as mayor of Waleska for several years and helped organize the Waleska Civic League in 1946.

He was a member of the Waleska Baptist Church, the Cherokee-Pickens Medical Society, Waleska Masonic Lodge No. 57 since 1888 and was Master of the Lodge for 20 years. He was also a member of the Cherokee Game and Fish Club.

Dr. Moore is survived by his children, Mr. Max Moore, Mrs. Claire Moore Brooks, and Miss Wilton Moore, all of Atlanta. His wife, the former Miss Lucy Sharpe, whom he married in 1889, died four years ago.

Funeral services were held at Reinhardt College Chapel; interment was in the church cemetery with the Waleska Masonic Lodge in charge of graveside rites. Members of the Cherokee-Pickens Medical Society served as an honorary escort.

JAMES R. WHITLEY, Winder, died on January 5, 1957, after a long illness. Dr. Whitley was 44 years of age at the time of his death.

A native of Dacula, Dr. Whitley attended the University of Georgia and was graduated from Emory University School of Medicine. He interned at Erlanger Hospital in Chattanooga and took postgraduate training in surgery at the Ochsner Clinic in New Orleans. He lived in Dalton before going to Winder to practice four years ago.

Funeral services were held at the Hebron Baptist Church with burial in the churchyard cemetery.

Surviving Dr. Whitley are his wife and a son, Bobby Whitley, of Winder; his parents, Mr. and Mrs. Taylor Whitley, Dacula; and two sisters.

SOCIETIES

The TENTH DISTRICT MEDICAL SOCIETY met on February 21, 1957, at the Eugene Talmadge Memorial Hospital in Augusta. at 9:00 a.m. the physicians played golf at the Augusta Country Club or attended surgical clinics at the Talmadge hospital; luncheon was served at the hospital and the scientific session followed. Curtis Carter, Augusta, presided, and scientific papers were presented by the following: J. A. Owen, Jr.—“Certain Aspects in Management of Diabetes”; William Moretz—“Management of Extremities with Arterial Insufficiency”; and John R. Fair—“Special Problems in Treatment of Eye Injuries”; Thomas Findley—“Edema in Renal Disease”; Floyd Blivin, Jr., —“Osteoporosis in the Aging”; and J. Kemble—“Evaluation of Convulsive Disorders.” A. W. Simpson, Jr., Washington, was nominated to serve as Councilor from the Tenth District to the Medical Association of Georgia; David R. Thomas, Augusta, was nominated to serve as vice-councilor.

BIBB COUNTY MEDICAL SOCIETY met on February 15 at Pinebrook Inn in Macon. The guest speaker for the meeting was Alfred S. Forbese, Associate Professor of Surgery of the Graduate School of Medicine of the University of Pennsylvania, who spoke on “Pancreatitis.” At the January 7 meeting of the Bibb County Medical Society, Mr. Eugene Cornelius, head of the local Social Security office, discussed Social Security as it affects doctors. A board of doctors to act as an advisory board for the local chapter

of the United Cerebral Palsy Association was appointed; they are Walter P. Barnes, Thomas H. Williams, John Paul Jones, William W. Orr, William H. M. Weaver, Robert A. Clark, Jr., and Thomas M. Hall. A medical panel on allergy, sponsored by the Junior League of Macon, was presented on February 10, 1957. Participating were the following physicians: W. Derrell Hazlehurst, Richard B. Ewing, Oscar S. Spivey, Duncan Walker, Jr., and William H. M. Weaver.

The DE KALB COUNTY MEDICAL SOCIETY met on January 28th and agreed to support in every way possible the work of the Red Cross Bloodmobile program. The society also has advised all civic organizations that it will be glad to supply speakers to address them on the recognition and treatment of cancer. At the meeting, the physicians were shown a film produced by the Upjohn Company on cancer. Members have also donated their services for a mass anti-polio inoculation drive in the schools of DeKalb County, Decatur, and Atlanta-in-DeKalb.

FULTON COUNTY MEDICAL SOCIETY met in January to hear a talk by Maxwell M. Berry, Atlanta, on peptic ulcers. Speaker at the society's February meeting was Milton F. Bryant, Atlanta, who spoke on surgery for artery obstructions. Dr. Bryant's paper was followed by a panel discussion of diseases of the arteries and veins. Participating in the discussion were Manuel N. Cooper, H. S. Weens, Fred R. Cooper, and Robert J. Van de Wetering.

GLYNN COUNTY MEDICAL SOCIETY met on January 25 with the Glynn County Mental Health Society to hear a talk on “Child Psychiatry” by George H. Preston, Fulton County Commissioner of Mental Hygiene and formerly commissioner of Mental Health for Maryland. The society also elected officers for 1957; they are as follows: C. A. Wilson, Brunswick, president; E. R. Jennings, Brunswick, vice-president; E. C. Kane, St. Simons Island, secretary-treasurer.

HABERSHAM COUNTY MEDICAL SOCIETY has elected the following officers for 1957: president—Joe J. Arrendale, Cornelia; vice-president—D. H. Garrison, Clarkes-

ville; and secretary - treasurer — Thomas N. Lumsden, Clarkesville.

SOUTH GEORGIA MEDICAL SOCIETY has elected the following officers for 1957: president—Joseph H. Brannen, Valdosta; vice-president—R. K. Winston, Valdosta; and secretary-treasurer—Lloyd L. Burns, Valdosta.

The **SOUTHWEST GEORGIA MEDICAL SOCIETY** met in Colquitt in January. John A. Meier, Albany, orthopedic surgeon, discussed injuries of the hand. The next meeting is scheduled for March 30th, Doctors' Day.

STEPHENS COUNTY MEDICAL SOCIETY met on January 24, 1957, to elect officers for the year 1957-58. They are as follows: president—R.H. Chaney, Jr., Toccoa; vice-president—P. B. Cleveland, Toccoa; and secretary-treasurer—C. L. Ayers, Toccoa.

The **WARE COUNTY MEDICAL SOCIETY** met on February 7, 1957, at the Okefenokee Golf Club in Waycross. Hosts for the meeting were W. C. Calhoun, W. S. Clark, and Floyd E. Davis. Dr. Davis showed a "Grand Rounds" closed circuit film prepared by Upjohn on the use of isotopes. Diagnostic and operative techniques in treatment of cancer was the subject for the scientific program. Mr. Sam M. Butler, Columbus, spoke on operation of the Blue Cross and Blue Shield hospitalization insurance plans. Mr. Butler is executive director of Blue Cross and Blue Shield in Columbus.

The following physicians were elected to serve as officers for the **WILKES COUNTY MEDICAL SOCIETY** for 1957: president—A. D. Duggan, Washington; vice-president—A. W. Simpson, Jr., Washington; and secretary-treasurer—M. C. Adair, Washington.

PERSONALS

At the annual meeting of Physicians' Service, Inc. (Blue Shield) 21 directors were elected. One-year directors elected were A. S. JOHNSON, Elberton, and C. D. HOLLIS, Albany. Two-year directors are H. W. SMITH, Swainsboro; F. T. McELREATH, Sandersville; F. R. MANN, JR., McRae; L. G. HICKS, JR., Clarkesville. Three-year direc-

tors are R. H. RANDOLPH, Athens; C. S. EASLEY, LaGrange; C. S. PITTMAN, JR., Tifton; R. C. EBERHARDT, Macon; H. A. THORNTON, Greensboro; and T. A. SAPPINGTON, Thomaston. Directors re-elected for three years are LAURIER E. HACKETT, Camilla; LUTHER H. WOLFF, Columbus; J. Z. McDANIEL, Albany; J. MARK MOTE, Columbus; O. T. GOWER, Cordele; E. L. WARD, Gainesville; and GEORGE L. EPPS, Columbus.

At the annual meeting of the Georgia Hospital Service Association (Blue Cross), the following physicians were elected to serve for three years on the board of trustees: HARRY B. BAXLEY, Donaldsonville; LUTHER H. WOLFF, Columbus; JACK C. HUGHSTON, Columbus; BRENT FOX, Columbus; W. P. JORDAN, Columbus; JAMES E. ELKINS, Columbus; J. A. CROWDIS, JR., Blakely; JAMES B. MARTIN, Edison; ENOCH CALLAWAY, LaGrange; W. W. AIKEN, Lyons; J. R. SMITH, Hahira; A. E. SIMS, Richland; and JAMES L. GRIST, JR., Clayton. JAMES A. ELKINS, Columbus, was elected to the executive committee.

First District

CARL BRENNAN and MILTON MAZO, Savannah, have announced the association in the practice of pediatrics with them of EDWIN C. SHEPHERD who has recently returned to Savannah after service in the U. S. Army. Dr. Shepherd is a native of Charleston, W. Va., but has lived in Savannah most of his life. He is a graduate of Savannah High School and Armstrong College. He received his B.S. degree from the University of Georgia and interned at Columbia (S. C.) Hospital and completed his pediatric training at the Children's Hospital of the District of Columbia. Dr. Shepherd practiced for two and a half years in Savannah before being recalled to active duty in the army.

W. U. CLARY, Savannah, recently addressed the members of the First District X-Ray Technicians' Society on the subject of "Radiography of the Skull and Spinal Column". His talk was illustrated with x-ray films.

In February Mr. and Mrs. Robert I. Feidelson of Lawrence, N. Y., formerly of Savannah, announced the

engagement of their daughter, Suzanne, to LAMONT E. DANZIG of Savannah. Dr. Danzig is an alumnus of The Citadel and the Medical College of South Carolina. He received postgraduate training at Cincinnati General Hospital, St. Luke's Hospital in Chicago, and Massachusetts Memorial Hospital in Boston. He also served in the U. S. Army Medical Corps and now practices internal medicine in Savannah. The wedding will take place in New York City.

JOHN L. ELLIOTT, Savannah, was re-elected president of the Physicians' Service Association of Savannah at the annual meeting held in Savannah in January. W. W. OSBORNE, Savannah, was named vice-president, and the following physicians were named directors: MONROE J. EPTING, CHARLES WESTERFIELD, T. A. PETERSON, and Dr. Osborne.

Jerry J. Everett, Savannah, has been made chief of the department of radiology at Memorial Hospital. Dr. Everett received his medical degree from the University of Arkansas School of Medicine and interned at Baltimore City Hospital. His residency training was at the Research Hospital in Kansas City, Mo. Before coming to Memorial, Dr. Everett served with the Veterans Administration in Big Springs, Texas, and was chief of the department of radiology at the Medical College of Alabama. He is a diplomate of the American Board of Radiology.

CURTIS HAMES, Claxton, attended a recent conference on Atherosclerosis and Coronary Heart Disease which was held in New York City. Before the conference he visited Massachusetts General Hospital and Harvard College in Boston and Cambridge.

LAWRENCE LEE, JR., Savannah, took office in January as president of the Chatham - Savannah Health Council, succeeding ANNE HOPKINS. Among other officers installed at the annual meeting were E. R. COOK, vice-president; WILLIAM WEICHSELBAUM, JR., president-elect; RUSKIN KING, trustee; A. J. KELLEY, trustee; S. FARNUM COFFIN, trustee; and PETER L. SCARDINO, trustee. Principal speaker at the meeting was William Peebles, public health officer for Montgomery County, Mary-

land. He discussed the medical care program in operation in Maryland. Dr. Peeples is a native Georgian and a former member of the Medical Association of Georgia, having been assistant health officer in Muscogee County before going to Maryland. His wife, Mary J. Peeples, was in the private practice of pediatrics in Columbus.

J. M. McELVEEN, Brooklet, celebrated his 80th birthday at his home in Brooklet on January 13, 1957. His children and grandchildren came from Statesboro, Covington, Savannah, and Brooklet to celebrate with him and Mrs. McElveen. Dr. McElveen practiced medicine in Brooklet for more than 50 years before his retirement a few months ago.

Morris L. Miller, Savannah, has been named chief of the department of anesthesiology of Memorial Hospital of Chatham County. Dr. Miller is a native of New York City and was educated in the public schools there and received a Ph.G. degree from the Long Island University School of Pharmacy, in 1931. He obtained his medical degree from the University of Louisville School of Medicine in 1938 and was later a research student in pharmacology at that school. Before coming to Savannah Dr. Miller was resident anesthesiologist at Jewish Hospital of Brooklyn and attending anesthesiologist and chief of the department at Queens General Hospital, Jamaica, N. Y. He was in private practice on Long Island from 1946 through 1954. Dr. Miller was instructor in anesthesiology at the University of Louisville School of Medicine from 1954 through 1956.

JOHN MOONEY, Statesboro, recently spent several weeks in post-graduate study in industrial medicine and surgery. He also attended the annual congress on Industrial Health at the Biltmore Hotel in Los Angeles, Calif., and spent some time at the home plant of the Rockwell Manufacturing Company in Pittsburgh, Pa.

IRVING VICTOR, Savannah, was chairman of the campaign to raise \$225,000 to expand science facilities at Armstrong College. The drive was conducted during the month of February. Dr. Victor has long been active in alumni affairs of Armstrong College, having been president of

the Alumni Association and last year's chairman of the endowment committee.

T. P. WARING, Savannah, has been elected vice-president of the Hospital Service Association of Savannah.

Second District

JAMES R. PAULK, JAMES T. FLYNN, JR., and ROBERT E. FOKES, JR., who now practice in the Eye, Ear, and Nose Clinic at 16 First Avenue in Moultrie are in the process of building a new clinic just a block behind the Vereen Memorial Hospital. The new building is to be one story of brick construction. It will have, in addition to waiting rooms, 19 treatment rooms, a library, and minor operating room.

The Board of Trustees of the Brooks County Hospital in January dedicated a memorial plaque honoring the late LEIGHTON ALEXANDER SMITH, Quitman, who died on May 7, 1956.

Third District

GUY DILLARD, Columbus, was the speaker at a recent meeting of the Lay Society of the Diabetes Association of Columbus. This society was organized in January to provide an opportunity for diabetics to hear the latest developments in control of the disease as well as to exchange recipes and other information.

C. C. GOSS, Ashburn, was the speaker at a recent meeting of the Kiwanis Club. He spoke on the importance of the Heart Fund Drive and pointed out that 53 per cent of all deaths in the U. S. are from heart disease and that in Turner County in 1956, 41 of the 77 deaths that occurred were from heart disease.

LEONARD T. MAHOLICK, Columbus, spoke at the St. Paul Methodist Church recently on the use of psychotherapy by ministers, physicians, attorneys, and social workers in helping people solve their emotional problems. Dr. Maholick, psychiatrist and director of the Bradley Center, defined psychotherapy as "an impersonal process between at least two persons—an individual in need (the patient) and a professionally trained individual in less need."

JOHN H. ROBINSON, III, Americus, has been elected president of

the medical staff of the Americus-Sumter County Hospital. Also elected to serve during 1957 were BON M. DURHAM, vice-president, and WILLIAM B. McMATH, secretary-treasurer.

Fourth District

Construction on a modern medical building was started in January in Forest Park by ERNEST A. DUNBAR, JR., and A. L. STONE, both of Forest Park. The building, which will have approximately 16 rooms, is at the corner of Main Street and Phillips Drive.

Officials of the Clark-Holder Clinic have announced that the clinic now located at 304 Church Street will be replaced by a larger, modern medical center, to be located at the corner of Smith Street and North Lewis Street. The clinic is an association of six doctors: JAMES S. HOLDER, JAMES W. CHAMBERS, C. MARK WHITEHEAD, WILLIS M. HENDRICKS, HENRY W. GRADY, and WILLIAM B. FACKLER.

ALEX D. JONES, Griffin, has been elected president of the Griffin-Spalding County Hospital staff for 1957. J. WELDON KELLEY has been elected president-elect and JOHN CLOUSE is the new secretary of the staff.

HENRY T. JONES, West Point, was elected president of the Valley Hospital medical staff at a recent meeting.

Ivory Suit, West Point, has assumed his duties as head of the department of anesthesiology at George H. Lanier Memorial Hospital. A native of Acworth, he is a graduate of the University of Tennessee Medical School and a former instructor in anesthesiology at the Medical College of Alabama in Birmingham.

JAMES R. THOMAS, Griffin, addressed the Griffin ABC Club recently on the prevention of paralytic polio. He said that polio could be almost completely wiped out if everyone took the three Salk vaccine shots prescribed for all people under 40 years of age. Dr. Thomas is the Spalding County Health Commissioner.

Officers of the medical staff of the Upson County Hospital for 1957 are as follows: president—H. D. TYLER, Thomaston; president-elect

(Personals)

—R. J. MINCEY; secretary-treasurer—R. J. MINCEY. J. M. KEL-LUM, Thomaston, is chief of surgery; W. J. GOWER, chief of medicine; J. W. WOODALL, chief of obstetrics and gynecology; and the Tissue Committee consists of the following physicians: W. J. GOWER, R. B. DALLAS, D. L. HEAD, JR., I. B. ROSS, and F. M. WOODALL.

Fifth District

The Atlanta Graduate Medical Assembly was held at the Atlanta Biltmore Hotel, February 18-20, 1957, with more than 1,000 doctors from over the nation in attendance. Guest speakers included Eugene Stead, professor and chairman of the department of medicine at Duke University School of Medicine and former dean of Emory University School of Medicine; Joseph Burchenal, Sloane-Kettering Institute, New York; Mark B. Coventry, Mayo Clinic; Donald Covalt, New York City; Howard Mahorner, Mahorner Clinic, New Orleans; and James G. Hughes, Le Bonheur Children's Hospital, Memphis, Tenn., and others.

EUSTACE A. ALLEN, Atlanta, has been appointed by the AMA Board of Trustees to serve on the National Legislation Committee as the "key man" representing the state of Georgia for 1957.

PIERCE ALLGOOD, ARTHUR M. PRUCE, GUY L. CALK, WINSTON E. BURDINE, and JOHN R. LEWIS, JR., all of Atlanta, participated in a regional meeting of the National Association of Claimants' Compensation Attorneys held in Atlanta, February 14-16, 1957.

HELEN W. BELLHOUSE, Atlanta, Maternal and Child Health Director, Georgia Department of Public Health, was visiting lecturer in Maternal and Child Health at the School of Public Health, University of North Carolina on February 15 and 16. Four such lectures are scheduled during the second semester. The School of Public Health of the University of North Carolina is one of 11 schools of public health in the U. S. and Canada and includes among its students many from foreign countries.

Dr. and Mrs. F. KELLs BOLLAND, JR., Dr. and Mrs. RUSSELL BURKE, and Dr. and Mrs.

HERSCHEL CRAWFORD, all of Atlanta, attended the American College of Surgeons' convention cruise aboard the SS Homeric in January. The ship stopped at six West Indies and South American ports, including a three-day stay in San Juan, Puerto Rico.

Geoffrey H. Bourne, Australian physician, has been named chairman of the anatomy department of Emory University it has been announced. The new Emory professor is now reader in histology at the London Hospital Medical College and is secretary of the British Society for Research on Ageing and secretary of the British Nutrition Society. Dr. Bourne is a graduate of the University of Western Australia and received the Ph. D. degree from the University of Oxford. Dr. Bourne will assume his duties at Emory in July.

W. E. BURDINE, Atlanta, has completed his course in law and has recently been awarded the LL. B. degree from the Woodrow Wilson College of Law in Atlanta.

ROLLA E. DYER, Emory University's director of research, took part in several medical research meetings in the Washington, D. C., area during the period February 7 through 20. He was the guest of honor at the Dyer Lecture Session, February 19 and 20, at the National Institutes of Health, Bethesda, Maryland. The lecture was named for Dr. Dyer, a former director of the institute.

Five Atlanta doctors spoke at a recent meeting of the Atlanta ileostomy and colostomy group. They are IRA FERGUSON, LON W. GROVE, MARVIN A. MITCHELL, R. H. STEPHENSON, and DAVID E. HEIN. The doctors took part in a panel discussion designed to help patients who have had either ileostomies or colostomies.

J. WILLIS HURST, Emory University, was guest speaker at a recent meeting of the Athens Kiwanis Club. He spoke on "Heart Attacks." Dr. Hurst was introduced by GOODLOE Y. ERWIN, Athens.

TED F. LEIGH, Emory University, has been made a fellow of the American College of Radiology, as have WILLIAM W. BRYAN, Atlanta, J. V. ROGERS, JR., Emory

University, H. S. WEENS, Atlanta, and DAVID ROBINSON, Savannah.

WILLIAM D. LOGAN, JR., Atlanta, has been elected president of the newly formed Atlanta Surgical Residents Society, composed of residents and assistant residents in eight Atlanta hospitals. RICHARD C. MARGESON is secretary-treasurer, and JOHN E. SKANDALAKIS is program chairman.

CARL C. PFEIFFER, Emory University, acting director of the division of basic health sciences at Emory University, has been elected vice-president of the Association for Research in Nervous and Mental Disease.

CARL A. WHITAKER, Atlanta, spoke at a recent meeting of the Skyland Elementary School P-TA.

Sixth District

CHARLES H. FIELD, Macon, announces the opening of his office in Macon for the practice of neurosurgery. Dr. Field is a native of Macon and a graduate of Vanderbilt University and the Medical College of Georgia. He interned at Vanderbilt University Hospital and spent two years in the U. S. Navy. He was in general practice in Birmingham for seven years before taking postgraduate work in neurosurgery at Bowman Gray School of Medicine in Winston-Salem, N. C. He practiced privately in Roanoke, Va., before coming to Macon. Dr. and Mrs. Field have three sons, Wayne, Robert, and Hyatt, and live at 2385 Vineville Avenue.

HERBERT M. OLNICK, Macon, spoke on "Nursing Aspects of Radiological Practice" before the Middle Georgia Hospital Alumnae group. Dr. Olnick is head of the department of radiology at the Middle Georgia Hospital, Macon.

JAMES W. PILCHER, Louisville, has joined the staff of Crawford W. Long Hospital in Atlanta and will move to Atlanta for residence.

S. J. SMITH, M. L. GREENE, and J. H. PRITCHETT, Monticello, held open house in their new office building on January 30, 1957, the day before opening the building for use.

Seventh District

ROBERT P. COGGINS, Marietta, was guest speaker at a recent

meeting of the Cobb County Chapter of the Georgia Association for the help of Retarded Children. Dr. Coggins is a graduate of Emory and the Medical College of Georgia. He has been in practice since 1955 in internal medicine and cardiology.

HUGH STEVENS COLQUITT, Marietta, announces the opening of his office in the Medical Arts Building for the practice of pediatrics. Dr. Colquitt is a graduate of the Medical College of Georgia; he interned at City Hospital of Winston-Salem, N. C., and served with the U. S. Navy before interning at Georgia Baptist Hospital in Atlanta. Dr. Colquitt practiced in Smyrna from 1947 until he was recalled to active duty with the Second Marine Division in 1953. After his discharge in 1955 Dr. Colquitt served a two-year residency in pediatrics at Grady Memorial Hospital in Atlanta.

Edward L. Groover, Marietta, has opened an office for the practice of general surgery at 1205 Roswell Street, the Medical Arts Building. Dr. Groover is a graduate of the Emory University School of Medicine and has had postgraduate training at the University of Virginia Hospital, Charlottesville, Va., Jefferson-Hillman, Birmingham, Ala., and at Louisville General and Children's Hospital.

PAUL B. REASER, Dalton, attended the meeting in Atlanta to launch the 1957 Heart Fund Campaign at which Paul Dudley White, Boston, was the guest speaker.

Alexander Szecsey, formerly of Atlanta, has joined the staff of the Bremen General Hospital. Dr. Szecsey is a general physician and surgeon with special interest in obstetrics and gynecology. A native of Hungary, Dr. Szecsey is a graduate of the Hungarian State University of Pecs. He served with the Hungarian Army and escaped from Hungary to Austria in 1945. He and his family came to the United States in March of 1951 under the auspices of the Church World Service. They became American citizens in June 1956. Since 1953, Dr. Szecsey has been on the staff of St. Joseph's Infirmary in Atlanta.

ERNEST THOMPSON, Monroe, is the new District Medical Director

for Douglas, Cobb and Paulding Counties. For the past 18 years he has been Walton County Health Commissioner at Monroe, a post he left January 1st to take over his new duties.

T. W. WHITFIELD, Dalton, has been elected president of the medical staff of Hamilton Memorial Hospital, succeeding A. M. BOOZER. Other officers are DAVID A. WELLS, vice-president, and LLOYD C. YEARGIN, secretary-treasurer.

Eighth District

E. D. BELL, Douglas, announces the reopening of his medical practice in a new office building located on the Ocilla Road across from the Douglas-Coffee County Hospital in Douglas. Dr. Bell recently returned to Douglas after two years study of general surgery at St. Elizabeth's Hospital in Lafayette, Indiana.

E. ADAMS DANEMAN, Waycross, announces the opening of his office at 505 Community Drive, Waycross, for the practice of psychiatry. Dr. Daneman comes to Waycross from Worcester State Hospital, Worcester, Mass.

ARTHUR M. KNIGHT, JR., Waycross, announces that a practical nurses' school has been started at the Memorial Hospital in Waycross. Classes began on February 1 and a new class will be started each February and September. Miss Mary Frances Faircloth and Mrs. Clara Branch are the director and assistant director respectively.

W. R. McCOY, Folkston, was chairman of the 1957 Heart Fund Drive in Charlton County.

At a recent meeting of the staff of Pineview General Hospital, Valdosta, the following officers were elected to serve during the 1957 term: president—RICHARD K. WINSTON; vice-president—G. J. AUSTIN; and secretary—JAMES S. MAUGHON.

Ninth District

H. M. EDGE, Blairsville, was the subject of a feature article in the *North Georgia News*; he was pictured beside his seven and a half foot grandfather clock, one of the 150 clocks that Dr. Edge has collected during the past few years.

E. H. ETHERIDGE, Winder, announces the re-opening of his office

on Candler Street, February 1, 1957, for the practice of medicine. Dr. and Mrs. Etheridge have been living in Washington for the past two years while Dr. Etheridge was on active duty with the U. S. Navy.

FLETCHER O. GARRISON, Demorest, is building a new office building in Cornelia, at the north end of Wayside Street. The building should be ready for use by the end of May, and Habersham County will have another modern medical building to add to the rapidly growing list of health facilities it has seen develop within its boundaries over the last few years.

A. A. ROGERS, JR., Commerce, spoke to members of the Pilot Club of Commerce on the need for a new hospital in that section of the state.

Tenth District

HAROLD E. CAMPBELL, Elberton, announces his association with A. S. JOHNSON, JR., and McALPIN H. ARNOLD, Elbert, in the practice of medicine. Dr. Campbell is a native of Lawrenceville and a graduate of the Medical College of Georgia. He interned at University Hospital and has spent the past two and a half years on the staff of the Milledgeville State Hospital.

JOSEPH D. LEE, Augusta, announces the opening of his office for the practice of general surgery at 1423 Gwinnett Street, Augusta.

LOUIS Q. J. MANGANIELLO, Augusta, was one of the physicians who participated with lawyers in the regional meeting of the National Association of Claimants' Compensation Attorneys, held in Atlanta, February 14-16.

J. H. ROBBINS, Athens, director, announces the appointment of Alexander Vanderburgh of Brewster, N. Y., and Mark Adams, Starke, Fla., to the medical staff of the Department of Student Health of the University of Georgia.

RAMON C. THOMPSON, Athens, has recently moved to Athens and opened an office at 765 S. Mill-edge Avenue for the practice of urology. Dr. Thompson is a graduate of Emory University School of Medicine, class of 1952. He completed four years of internship and residency training in urology at Grady Memorial Hospital in Atlanta in June 1956.

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyrighted, 1957, by the Medical Association of Georgia, 875 West Peachtree Street, N.E., Atlanta 9, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; \$1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.

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COVER

The whole family is lined up for Salk Vaccine shots — take it upon yourself to see that all people between the ages of one and 40 get their vaccinations before the polio season starts and *strike your blow at polio*. Photo by Ted F. Leigh, M.D. See also p. 170 and 191.

MAG Organization

Officers

President—Hal M. Davison, Atlanta
President-Elect—W. Bruce Schaefer, Toccoa
First Vice-President—Carl C. Aven, Marietta
Second Vice-President—Bernard P. Wolff, Atlanta
Secretary-Treasurer—David Henry Poer, Atlanta
House of Delegates Speaker—Thomas W. Goodwin, Augusta
House of Delegates Vice-Speaker—Fred H. Simonton, Chickamauga

Delegates to the AMA

Delegate—C. H. Richardson, Sr., Macon (1957)
Alternate—C. L. Ayers, Toccoa (1957)
Delegate—Eustace A. Allen, Atlanta (1958)
Alternate—William R. Dancy, Savannah (1958)
Delegate—Spencer A. Kirkland, Atlanta (1958)
Alternate—Henry H. Tift, Macon (1958)

Councilors

District

- 1—Lee Howard, Sr., Savannah (1958)
- 2—George R. Dillinger, Thomasville (1958), *Acting Chairman of Council*
- 3—W. G. Elliott, Cuthbert (1958)
- 4—J. W. Chambers, LaGrange (1958), *Chairman*
- 5—J. G. McDaniel, Atlanta (1959)
- 6—Henry H. Tift, Macon (1959)
- 7—D. Lloyd Wood, Dalton (1959)
- 8—F. G. Eldridge, Valdosta (1959)
- 9—Charles R. Andrews, Canton (1957)
- 10—H. L. Cheves, Union Point (1957)

Vice-Councilors

District

- 1—Charles T. Brown, Guyton (1958)
- 2—J. Z. McDaniel, Albany (1958)
- 3—Luther H. Wolff, Columbus (1958)
- 4—Clarence B. Palmer, Covington (1958)
- 5—Charles S. Jones, Atlanta (1959)
- 6—George H. Alexander, Forsyth (1959)
- 7—Ralph W. Fowler, Marietta (1959)
- 8—James N. Hicks, Brunswick (1959)
- 9—
- 10—J. Victor Roule, Augusta (1957)

Committees of Council

Executive Committee

Hal M. Davison, Atlanta, *President*
W. Bruce Schaefer, Toccoa, *President-Elect*
H. Dawson Allen, Jr., Milledgeville, *Immediate Past President*
David Henry Poer, Atlanta, *Secretary-Treasurer*
J. W. Chambers, LaGrange, *Chairman of Council*
George R. Dillinger, Thomasville, *Acting Chairman of Council*

Finance

J. G. McDaniel, Atlanta, *Chairman*
D. Lloyd Wood, Dalton

Legal Counsel

Hal M. Davison, Atlanta, *Chairman*
W. Bruce Schaefer, Toccoa
Bernard P. Wolff, Atlanta
Charles S. Jones, Atlanta

Reserve Fund

W. G. Elliott, Cuthbert, *Chairman*
Henry H. Tift, Macon
George R. Dillinger, Thomasville

Cultists

Thomas W. Goodwin, Augusta, *Chairman*
Henry H. Tift, Macon
F. G. Eldridge, Valdosta

Institution-Physician Relations

Henry H. Tift, Macon, *Chairman*
Milford B. Hatcher, Macon
W. W. Bryan, Atlanta (Radiology)
Lester Rumble, Jr., Atlanta (Anesthesiology)
G. Darrell Ayer, Atlanta (Pathology)
Lee Howard, Sr., Savannah, *ex-officio*

MAG-Hospital Association

Charles R. Andrews, Canton, *Chairman*
Luther H. Wolff, Columbus
Mr. George H. Stone, Thomasville
Mr. Daniel E. Gay, Savannah

Annual Session

J. G. McDaniel, Atlanta, *Chairman*
Henry H. Tift, Macon
J. W. Chambers, LaGrange
David Henry Poer, Atlanta
George R. Dillinger, Thomasville

Headquarters Building

Carl C. Aven, Marietta, *Chairman*
John W. Turner, Atlanta
Hal M. Davison, Atlanta

Honorary Advisory Board

J. W. Palmer, Ailey	President, 1918-1919
C. K. Sharp, Arlington	President, 1928-1929
William R. Dancy, Savannah	President, 1929-1930
M. M. Head, Zebulon	President, 1932-1933
C. H. Richardson, Macon	President, 1933-1934
Clarence L. Ayers, Toccoa	President, 1934-1935
B. H. Minchew, Waycross	President, 1936-1937
Grady N. Coker, Canton	President, 1938-1939
J. C. Patterson, Cuthbert	President, 1940-1941
Allen H. Bunce, Atlanta	President, 1941-1942
James A. Redfearn, Albany	President, 1942-1943
W. A. Selman, Atlanta	President, 1943-1944
Cleveland Thompson, Waynesboro	President, 1944-1945
Ralph H. Chaney, Augusta	President, 1946-1947
Enoch Callaway, LaGrange	President, 1949-1950
A. M. Phillips, Macon	President, 1950-1951
W. F. Reavis, Waycross	President, 1951-1952
C. F. Holton, Savannah	President, 1952-1953
William P. Harbin, Jr., Rome	President, 1953-1954
H. Dawson Allen, Jr., Milledgeville	President, 1955-1956

Committee Chairmen

Legislation—M. F. Simmons, Decatur
Medical Education—R. C. McGahee, Augusta
Medical Defense—W. L. Pomeroy, Waycross
Professional Conduct—A. M. Phillips, Macon
History and Vital Statistics—J. Calvin Weaver, Atlanta
Public Health—T. A. Sappington, Thomaston
Maternal and Infant Welfare—Charles M. Mulherin, Augusta
Rural Health—J. L. Walker, Clarkesville
Industrial Health—Duncan Shepard, Atlanta
Public Service—Chris J. McLoughlin, Atlanta
Cancer—J. E. Scarborough, Emory University
Insurance and Economics—David R. Thomas, Augusta
Veterans' Affairs—Hartwell Joiner, Gainesville
Constitution and By-Laws—Thomas W. Goodwin, Augusta
Scientific Exhibit Awards—Ted F. Leigh, Emory University
Woman's Auxiliary—Edgar M. Dunstan, Atlanta
Hospital Relations—Milford B. Hatcher, Macon
Crawford W. Long Memorial—Lester Rumble, Jr., Atlanta
Mental Health—Rives Chalmers, Atlanta
Geriatrics—Edgar Woody, Jr., Atlanta
Medical Civil Preparedness—Edgar M. Dunstan, Atlanta
American Medical Education Foundation—Ben K. Looper, Canton
Blood Banks—Warren B. Matthews, Marietta
Abner Wellborn Calhoun Lectureship—Glenville Giddings, Atlanta
Crippled Children—J. C. Hughston, Columbus

State Boards

State Board of Medical Examiners—Albert M. Deal, Statesboro, *President*
Medical Examiners State Board of Workmen's Compensation—Hugh Hailey, Atlanta, *Chairman*
State Board of Health—R. Lee Rogers, Gainesville, *Chairman*
State Medical Education Board—John W. Mauldin, Lawrenceville, *Chairman*
Hospital Advisory Council—Mr. Oscar Hilliard, Fort Oglethorpe, *Chairman*

Related Committee

Medical Advisory to Selective Service—David Henry Poer, Atlanta, *Chairman*

Specialty Section Chairmen

Anesthesiology—Lloyd Osteen, Savannah
Diabetes—C. Raymond Arp, Atlanta
General Practice—Harold Smith, Savannah
Industrial Surgery—C. F. Holton, Savannah
Medicine—T. A. McGoldrick, Savannah
Obstetrics and Gynecology—Albert J. Kelley, Savannah
Ophthalmology and Otolaryngology—John K. Train, Jr., Savannah
Orthopedics—Ruth Waring, Savannah
Pathology—Lee Howard, Jr., Savannah
Pediatrics—Howard J. Morrison, Savannah
Psychiatry—William A. Smith, Atlanta
Radiology—John B. Rabun, Savannah
Surgery—Julian Quattlebaum, Savannah
Thoracic Medicine—William A. Hopkins, Atlanta
Urology—J. Z. McDaniel, Albany

The Executive Secretary's LETTER

AN AMENDMENT TO THE Medical Practice Act of Georgia, sponsored by the State Board of Medical Examiners and the Medical Association of Georgia, was approved at the recent session of the Georgia General Assembly. The Amendment gives broad powers to the Board of Examiners in revoking and suspending licenses to practice medicine. It lists some 20 reasons why the Board may revoke or suspend a physician's license.

The new amendment (see page 152) also grants to the Board of Examiners the right to petition for injunction against unauthorized practices. This injunctive provision may not be used against "any person licensed by any examining board," other than the medical examining board, and it may also be used against persons practicing medicine without any type of professional or trade license.

Osteopathic Legislation

A bill to permit osteopaths in Georgia to practice medicine remained in a subcommittee of the House Hygiene & Sanitation Committee, but it will probably come up again when the Legislature reconvenes in January 1958. This bill redefined osteopathy as "a complete school of the healing art, applicable to all types and conditions of diseases and disorders." The bill stated further that the practice of osteopathy "in all its branches" includes "operative surgery, obstetrics, and the use of drugs according to recognized therapeutic practices."

The Medical Association of Georgia opposed this bill on the grounds that osteopath schools are not of sufficiently high standards to qualify their graduates to practice medicine.

On the last day of the General Assembly, a resolution was adopted in the Senate to establish a three-man study committee to study the osteopathic profession and osteopathic schools. This committee will probably be composed of Senator Grover Newman of Bremen, Senator Bobby Lee Cook of Summer-ville, and Senator Alvin Foster of Forest Park, the authors of the resolution.

The "Heart Bill"

A bill sponsored by the Medical Association of Georgia and the Georgia Heart Association to permit employers to hire cardiac patients without fear of liability under the Workmen's Compensation Law failed to be reported out of the Senate Health and Welfare Committee after an extensive public hearing. The bill met stiff opposition from plaintiff attorneys and organized labor. In effect, the bill stated that in-

jury under the Workmen's Compensation Act would not include "heart disease, heart attack, the failure or occlusion of any coronary blood vessels, cerebral hemorrhage or thrombosis, epilepsy, or diabetic seizure, resulting from or during the performance of the usual work of employment."

Indigent Care

Hospital Care for the Indigent was provided in a state-wide legislative program adopted by the Legislature, but no funds were appropriated for its implementation. This program will have to wait until another session of the Legislature to be activated. Also adopted was a companion bill authorizing the welfare department to provide matching funds for hospital and medical care payments to welfare recipients.

Miscellaneous Bills

Other bills passed at the recent session of the Legislature are as follows:

1. A bill permitting county boards of education to require vaccination against polio as a prerequisite for admission to school except for religious objections, for reasons of health, or because of previous adverse reaction to vaccination.

2. A study commission to authorize a study of "mental health" problems in Georgia.

3. A committee to study the possibility of using the old Piedmont Hospital building in Atlanta as a screening center in connection with the Milledgeville State Hospital.

4. Bills raising the compensation of the director of the State Department of Public Health and the per diem of the members of the State Board of Health.

5. A bill providing funds for the establishment of a facility for Negro mentally defective children at Gracewood.

Bills Failing to Pass

Other bills which failed to pass were as follows:

1. A bill to designate chiroprodists "participating physicians" under the Non Profit Medical Service Act of 1950.

2. A bill sponsored by the Human Betterment League of Augusta (supported by MAG) to permit sterilizations outside mental and penal institutions.

3. A bill to provide scholarships for student nurses under the State Medical Education Board.

4. A bill relating to temporary licenses issued by the State Board of Medical Examiners and providing for "institutional licenses" to be issued by the Board. (Sponsored by the Board and MAG.)

H. B. No. 53 (AM)

By Messrs. Allen and Fordham of Bulloch, Lanier of Candler, and others.

AN ACT

To amend Section 84-916 of the Code of Georgia of 1933 relating to refusal or revocation of licenses to practice medicine so as to provide for the grounds and conditions thereof; the right of investigation; to authorize the Board of Medical Examiners upon proof that an applicant or licentiate has been guilty of any of the prohibited offenses to refuse to grant a license to such applicant and to suspend for a specified time to be determined by the Board, or revoke the license of, said licentiate upon a majority vote; to authorize the suspension of the license of any licentiate adjudicated mentally incompetent or insane upon filing with the Board a certified copy of such adjudication; to provide as an additional remedy the right of injunction to the Board against the violation of any of the provisions of the Chapter or any of the laws of the State of Georgia relating to the practice of medicine; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1

Section 84-916 of the Civil Code of Georgia of 1933 is hereby repealed and a new Section 84-916 of the Code of Georgia of 1933 is submitted in lieu thereof to read as follows:

"84-916. Refusal or revocation of licenses to practice medicine; Grounds.—The Board of Medical Examiners may refuse to grant a license to practice medicine and it shall have the power and it is its duty to suspend for a specified time to be determined in the discretion of the Board or revoke any license to practice medicine in the State of Georgia on the following grounds; to-wit:

(1) The intentional use of any false, fraudulent or forged statement or document, or the use of any fraudulent, deceitful, dishonest or immoral practice, in connection with any of the licensing requirements as provided for in this Chapter.

(2) The commission of a crime involving moral turpitude; the conviction of a crime involving moral turpitude shall be conclusive evidence of the commission of such crime and a fine or sentence based on a plea of nolo contendere shall be equivalent to conviction. For the purpose of this Act a conviction, plea of guilty or plea of nolo contendere to a charge or indictment by either Federal or State Governments for income tax evasions shall not be considered a crime involving moral turpitude.

(3) The violation of any penal provision of the "Opium Act of 1914" or the "Harrison Narcotic Law"; a conviction for the violation thereof; and a

fine or sentence based on a plea of nolo contendere shall be equivalent to conviction;

(4) The practice of medicine under a false or assumed name or the impersonation of another practitioner of a like or different name;

(5) Habitual intemperance in the use of ardent spirits, narcotics, or stimulants to such an extent as to render the licentiate unsafe or unfit for the performance of his professional duties;

(6) The performance of an unlawful abortion or assisting or advising the performance of any unlawful abortion;

(7) The obtaining of a fee on a representation that a manifestly incurable disease can be permanently cured;

(8) Causing the publication or circulation of an advertisement of any medicine by means whereof the monthly periods of women can be regulated or the menses, if suppressed, can be re-established;

(9) Causing the publication or circulation of an advertisement relative to any disease of the sexual organs;

(10) Use of untruthful or improbable statements, or flamboyant or extravagant claims concerning such licensee's professional excellence of abilities;

(11) The advertising for the practice of medicine in any unethical or unprofessional manner;

(12) Distribution of intoxicating liquors or drugs for any other than lawful purposes;

(13) Wilful or repeated violation of this Chapter or the rules and regulations of the Department of Public Health governing the control of communicable diseases;

(14) Operation of, or connection with or employment by any person, corporation, company, professional school, clinic, or institution that advertises by the use of hand bills, posters, circulars, cards, neon or other electric signs, radio, newspaper, or any kind of printed or written publications to make examinations of the eyes for glasses, cure or treat cancer or any other disease, or to give free examinations;

(15) Sustaining any physical or mental disability which renders the further practice of medicine dangerous;

(16) The performance of any dishonorable, unethical, or unprofessional conduct likely to deceive, defraud, or harm the public;

(17) The use of any false or fraudulent statement in any document connected with the practice of medicine;

(18) Knowingly performing any act which in any way assists an unlicensed person, or persons, firm, association, or corporation to practice medicine or permitting or allowing another to use his license or certificate to practice medicine in this state, for the purpose of treating, or offering to treat, sick, injured, or afflicted human beings.

(19) Violating or attempting to violate, directly or indirectly or assisting in or abetting the violation of or conspiring to violate any provision or terms of a medical practice act;

(20) Division of fees or agreeing to split or divide the fees received for professional services with any person, or persons, firm, association or corporation for bringing or referring a patient;

Said Board may, upon satisfactory proof made, that any applicant or licentiate has been guilty of any of the offenses above enumerated, refuse to grant a license to said applicant, and shall have the power, pursuant to the provisions of this Chapter relative to notice and hearing, to suspend for a specified time to be determined by the discretion of the Board, or revoke the license of, said licentiate upon a majority vote.

The Joint Secretary, State Examining Board, is hereby vested with the power and authority to make such investigations in connection with the enforcement of the provisions of this Chapter as he, or the Board of Medical Examiners, or any Solicitor General, may deem necessary or advisable; and the result of all investigations shall be reported to and the records thereof shall be kept by, the said Board of Medical Examiners.

If any person holding a license to practice medicine in this State by any final order of adjudication by any court of competent jurisdiction, be adjudged to be mentally incompetent or insane, the license of such licentiate shall automatically be suspended by the Board of Medical Examiners upon filing with them of a certified copy of such adjudication and nothing in this Chapter to the contrary notwithstanding such suspension shall continue until the licentiate is found or adjudged by such court to be restored to reason or until he is duly discharged as restored to reason in any other manner provided by law.

SECTION 2

A new section shall be added to Chapter 84-9 of the Code of Georgia of 1933 to be known as and numbered 84-929, as follows:

“84-929. Injunction of Illegal Practices; Petitioned by Board.—In addition to any other remedy or criminal prosecution, whenever it shall appear to the Board of Medical Examiners that any person or persons, firm, company, partnership, association, or corporation or their agents, officers, or directors is/are or has/have been violating any of the provisions of this Chapter, or any of the laws of the State of Georgia relating to the practice of medicine, said Board may, on its own motion or on the verified complaint in writing of any person, file an equitable petition in its own name in the superior court in any county of this state having jurisdiction of the parties, alleging the facts and praying for a temporary restraining order and an injunction and permanent injunction against such person or persons, firm, company, partnership, association, or corporation and their agents, officers and directors, restraining him, her, it, or them, from violating such law, and, upon proof thereof, the said court shall issue such restraining order, injunction and permanent injunction, without requiring allegation or proof that the petitioner therefor has no adequate remedy at law. No restraining order, or injunction, whether temporary, permanent or otherwise, shall be granted, without a hearing after at least ten (10) days' notice. It is hereby declared that such violation or violations of the provisions of this Chapter is or are a menace and a nuisance dangerous to the public health, safety and welfare. This code section shall not apply to any licensed practitioner of the healing arts who is practicing his profession as provided in any other law under which such practitioner is licensed. Provided, that no injunction or restraining order, as provided herein, shall be issued against any person licensed by any examining board created under the laws of Georgia, other than the medical examining board.”

SECTION 3


BE IT FURTHER ENACTED that all laws and parts of laws in conflict herewith be and the same hereby are repealed.

See You in Savannah

April 28 - May 1, 1957

***103rd Annual Session - Medical Association of Georgia**

Hotel DeSoto, Savannah, Georgia

A woman with dark hair, wearing a white long-sleeved shirt and dark pants, is standing on a wooden step ladder. She is holding a paintbrush in her right hand and painting the ceiling. A light fixture hangs from the ceiling. To her left is a doorway with a white curtain. To her right is a doorway with a white door. On the floor next to the ladder is a white bucket of paint and a paintbrush. The room has yellow walls and a white floor.

Mom “wears
the pants”
once too
often



The Manger Hotel



The Oglethorpe Hotel



Hotel DeSoto

SAVANNAH

Scene of the *103rd Annual Session
April 28 - May 1



A Walk in Forsyth Park



Beacon Light



Savannah Chamber of Commerce

The Eugene Talmadge Memorial (High Level) Bridge over the Savannah River



Savannah Then and Now, 1804-1957

ANNE Mc HENRY HOPKINS, M.D., Savannah, Georgia

WE ARE ONLY AS GOOD as our tools. This is a startling statement on the eve of the 103rd Annual Session of the Medical Association of Georgia. It is especially startling coming from a member of the Georgia Medical Society, which is so proud of its age, its roots, and its heritage.

The change in the practice of medicine in Savannah from the earliest days, even compared with practice at the turn of the century, is stupendous and, of course, for the better. So when I was asked as historian of our society to write an article for the April *Journal* contrasting the present day practice with that of the early days in Savannah, I thought it would almost write itself it was so obvious. There are always two points of view about the past. The older members are inclined to think the good old days were the best, and the younger men think all systems of practice old fashioned except their own. Soon after starting practice here, I was appointed custodian of our historic papers and articles. I have sorted a great many, read and reread some, and searched for information in others. During the 1920's, I was a technician in the Savannah Public Health Laboratory and later in a hospital laboratory, and I knew the doctors and the practice of medicine in Savannah very well. From this vantage point, I can see only two fundamental differences in the practice of medicine then and now. One is the development of specialization necessitated by the tremendous increase in scientific knowledge. The other is in the more commercial attitude that doctors now have toward their profession. In the early days, the profession drew from the wealthy families or the families of doctors, ministers, or lawyers. Thanks to our wonderful American democracy, a doctor now can have been a rail-splitter, a Groton school boy, or a descendant of the Sea Island slaves, whose "gullah" talk made them seem almost less than human at that time. This I think is good. Thanks to our compulsory taxation, money is of necessity more impor-

tant. Dr. T. P. Waring in his recollections of 50 years in medicine was grateful in 1895 just to be taken in as a junior partner of an established physician to learn from him and to inherit some of the older man's patients when he retired. Today, *Medical Economics* advises the young resident about to go into practice on the income he must be assured before he accepts a partnership. I also believe that various devices are being suggested whereby the doctor may be assured of his fee before giving service. A few doctors even ask the patient if he has money enough to pay the fee. This trend represents, I think, a real difference between the old days and the new. The doctor is becoming a better business man. Whether this will produce a difference in the quality of medicine, making it less humane, remains to be seen.

We look back on the medicine of the old days and pity the fumbling ignorance in which doctors worked. Superficially the differences are great but are due only to the accident of greater educational facilities and advances in scientific knowledge. This was said better by Dr. Eugene Corson in his address at the Centennial Anniversary of the Georgia Medical Society in 1904: "We cannot fail to see that true greatness is independent of time and place and that real genius is ever the same, the only difference being in the opportunities offered for its effective play." He went on to point out that three events had radically changed the field of medicine: (1) the discovery of anaesthesia, (2) the discovery of the bacterial origin of disease and of antiseptics and asepsis, and (3) the discovery of X-ray. (Dr. Corson himself did early and original work in X-ray while continuing an active general practice and passing on to his patients the basic principles of cleanliness and asepsis.)

By our standards, the 14 men who petitioned the State Legislature to incorporate our society were indeed untrained. Noble Wymberly Jones, the president, had received only a smattering of medical

training from his father; only two of the men had M.D. degrees. They incorporated for "the purpose of lessening fatality induced by climate and incidental causes", but they also incorporated to improve "the science of Medicine." Our "science of Medicine" having "advanced" by 153 years, climate does not play the same part in our efforts to lessen fatality. The dreadful fevers are not our chief concern. Yellow fever epidemics recurred until the end of the last century, and malaria and typhoid through the early decades of this one. However, the emphasis in these early days was on the effect of "climate." Rice was cultivated right up to the very edges of the city and even to the door-sills of the houses, and the stagnant water or the putrefaction on the soil when the water was drained off was the first object of concern to the medical profession. It took about 13 years to bring about a change. A survey was made and many papers were written, the people were roused. Most difficult of all, the planters were persuaded for \$40 an acre to grow within the radius of a mile of the city only things which required dry culture and to keep this land well ditched and drained. The results were rewarding although bacilli, virus, bacteria, and plasmodia were still unknown. The citizens of Savannah, through bonds and voluntary donations, paid \$200,000 to complete this project at a time when the population was between four and five thousand, half of whom were slaves. This feat is impressive, and I should think unsurpassed by us so far, even in this day of enormous Community Chest Funds.

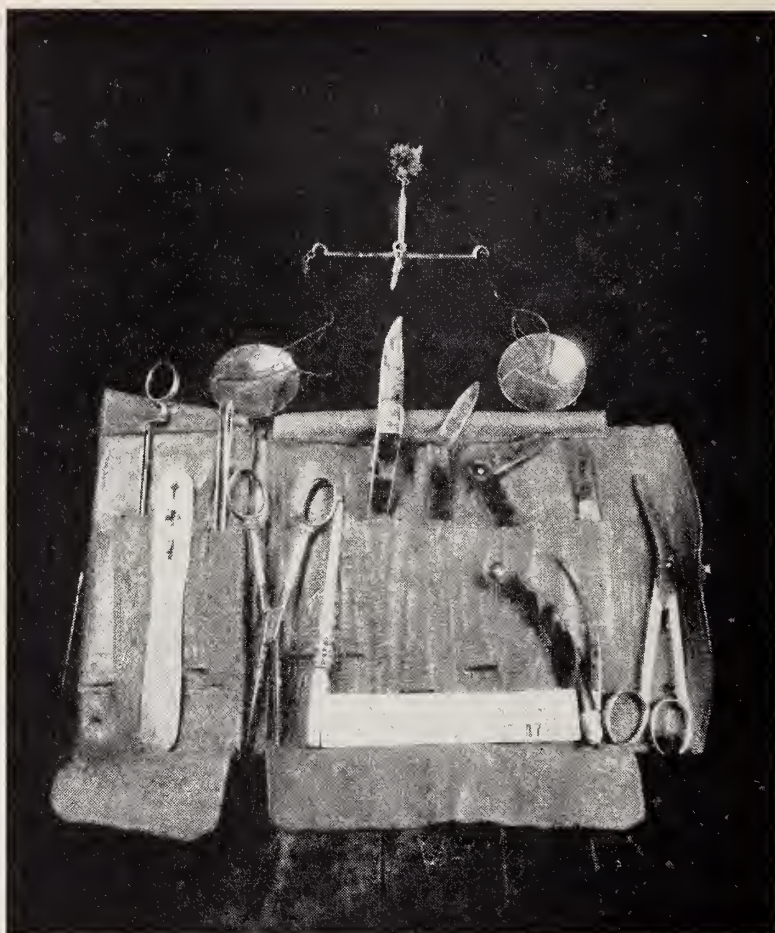
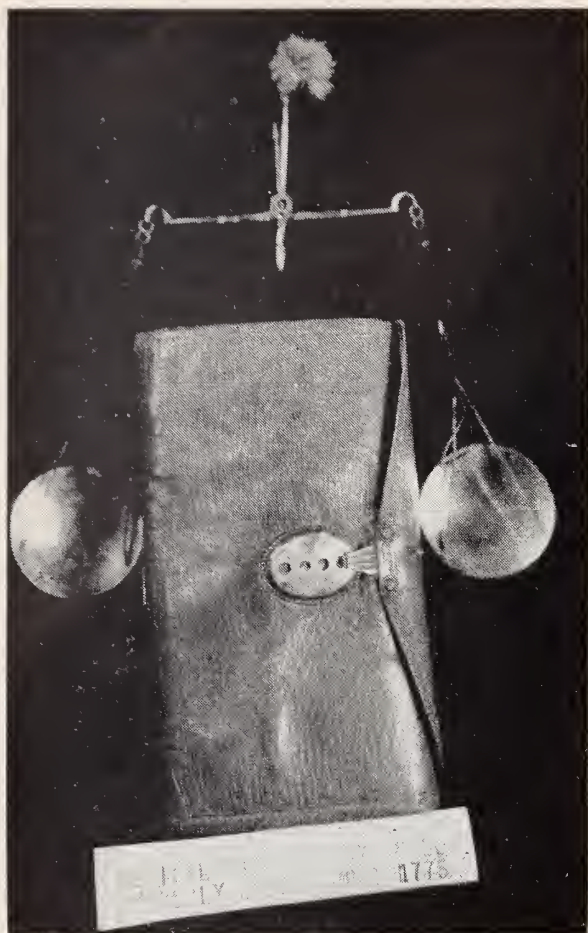
The next preoccupation of the early days was to raise the standards of practice. Within 10 or 12 years of its founding the Savannah Society petitioned the legislature for a law allowing licensure by the society and examination of all new members by a committee. A few years later this became a state function. There were few medical schools in these early days, but young men were encouraged and helped to attend them. There were few journals, but Savannah doctors exchanged views with doctors in Charleston, Philadelphia, and New York by correspondence. A medical library was started as early as 1807. Papers were written and presented at each weekly meeting. As early as 1838, a charter was applied for and granted to establish the Savannah Medical College. By this time only a fourth of the doctors practicing had medical degrees. The college was built with \$40,000 subscribed out of the pockets of the faculty, who were the busy physicians of that day but who probably realized that in teaching they benefited the most. It did not open until 1852. The college closed temporarily during the War Between the States and permanently in 1881, but not

before a rival school, Oglethorpe College, was opened. Both closed at about the same time.

Savannah since World War II boasts a society of doctors whose training represents all the best medical schools in the country. There are board specialists in every field. A Medical Journal Club, Surgical Society, and Obstetric-Pediatric Society have been formed for study and exchange of ideas. Through the private office of one of our neurologists we have the facility of electroencephalograms, and through another private office the use of I_{131} in diagnosis and treatment. A clinic for alcoholism is not quite a year old, and a center for physical rehabilitation has just started operations. Special heart, tumor, prenatal, and crippled children clinics have been in operation for some time. Savannah's most recent addition to medical progress and one we have acquired since the last state meeting here is the Memorial Hospital of Chatham County, built in memory of World War II Veterans. This has been in operation for over a year and has been approved by the Council on Medical Education and Hospitals of the American Medical Association. We hope that before long it will be a full-fledged teaching hospital. Agitation by some of the doctors for such a hospital was started as long as 30 years ago. In the last 10 years the hard and time-consuming efforts of many of our members, of veterans' representatives, of our health officer, and of public-spirited citizens have made the dream a reality.

Across from the grounds of the new hospital there is a medical center. Twenty or more office units are just being completed, and many of the doctors have moved in. Included are a general practitioner, a clinical laboratory, X-ray laboratory, and representatives of almost every specialty in medicine. This represents a far cry from the days when the doctor's office was in his home, which was usually at least two-storied, and he could come down in his night clothes, treat the midnight emergency, and dispense his own pills. One of our leading pediatricians still maintains his office in his home and another still dispenses pills. It is easy to see the advantages and disadvantages of both systems.

As the doctors have received cooperation in their projects from the citizens of Savannah so too have they taken part in a wide variety of civic activities. In the early 1800's the city had a population of 5,000 and about 20 doctors. Although transportation was by horse and buggy, the city was smaller, and the distant calls were largely to plantations where several patients were treated on one visit. (The plantation owner was the industrialist of that time and "contract" medicine started then.) In other words the doctor, between epidemics, had more free



The medical kit used by Noble Wymerly Jones about 1775

time. Many a doctor served as mayor or legislator and many more as alderman or health officer. It was only in the late 1890's that the health officer became a full-time, salaried official. As an extreme example of public service, Dr. Richard Arnold, who had the biggest practice of his day among both wealthy and free patients, served as mayor four times and also as a legislator. He helped found the Georgia Historical Society and Savannah Board of Education. Besides these civic activities he served as president of the Georgia Medical Society and as a representative at the incorporating meetings of both the A.M.A. and the M.A.G. He was vice-president and later president of the state association and vice-president of the A.M.A. He was also one of the prime instigators in organizing the Savannah Medical College, and he served on its faculty.

Now, in spite of a population of 150,000 and the increased patient load, we have continued to have doctor representation on the Board of Aldermen. Doctors give freely of their time to the fields of general education, art, music, religion, to Historic Savannah, and all phases of life in the city. Like the father of our Society, Noble Wymerly Jones, a "patriot" and revolutionist, and like the "volunteers" in the "Civil War," most of our members have seen military service. Many of them were in combat, and one lost his life.

There are several women doctors practicing in Savannah today. In view of the present television showing of the life of Elizabeth Blackwell, who was licensed to practice medicine in 1849, it is interesting to know there was a Dr. Mary Lavinder, a native Savannahian, in practice here as early as 1810. Her obituary in 1845 by its length and wording shows she held the respect of the citizens and that although her work was mainly obstetrical it also included medical practice for women and children. She was not allowed to matriculate at the medical school in Philadelphia, but was taught there privately by one of the professors. Her ability and name reached the ears of Drs. Warren and Jackson in Boston, who wished to give up their obstetrical practice and wanted her to take over for them. She, however, remained in Savannah.

In comparing old and new customs, time has lent enchantment to the past, no doubt. Many of the meetings, with pheasant and champagne among the items served, were epicurean feasts; but they may have had uncomfortable aftermaths for many. The style of writing and oratory was full of literary allusions and in many cases extremely flowery. The anniversary of the Georgia Medical Society was celebrated by a public procession of the Society from its "rooms" to the Bay where an oration took place in the open. Dr. Arnold, in one of these addresses,



Savannah-Candler Hospital in 1830



Warren A. Candler Hospital 1957



Georgia Infirmary, Chartered December 24, 1832

stated their purpose: to "in some measure show our real condition and the just claims we have on the confidence of the public, as men honestly and conscientiously laboring for the advancement of Truth and Science in our profession." I suppose the anniversary orations were a form of public relations. There is no report as to whether they were as well attended as the medical forums put on by the Society in the past few years here.

The greatest contrast between past and present is in treatment. Bleeding used to be a common practice. In reading a hospital record of a surgical patient of about 1900, I was shocked by the amount of post-operative morphine and the drastic purging which continued for days after surgery. Yet in the early days of our intravenous replacement therapy, it too was undoubtedly overdone. The description of the operating room at that time included lint, safety pins, pillows, blankets, carbolic spray, ether, morphine, ice, champagne, and mustard. The comfort and care of the patient were well provided for. Thanks to our knowledge of bacteria and asepsis, physiology, pharmacology, and anaesthesia, our technique today is far superior, our purpose the same. Surgery now has almost no limitations, whereas from a study of fee bills of the early days it was limited to the body surface, fractures, and paracentesis. Ovariectomy was reported at a state meeting as early as 1871. In 1873, a paper on "Normal Ovariectomy" was read by Dr. Robert Battey; that was an operation for which he received great credit. I quote his paper in part: "I doubt not that it is known to you that I have invaded the hidden recesses of the female organism and snatched from its appointed seat a glandular body whose mysterious and wonderful functions are of the highest interest to the human race—nay, an organ endowed with functions, the integrity of which determines the very existence of the race itself. For having done this I trust I will not be assassinated, neither in my carriage at home, nor in this hall, nor yet upon the streets of your orderly city. Those of you, my brethren, who know me personally, I hope will scarcely need the assurance that I have not taken this step forward without due and deliberate thought. Whatever may be your opinions of the wisdom of my course, I trust you will see in it evidences of a heart not devoid of human sympathy, of a mind not shirking professional labor, of a hand not fearing to lift itself when duty calls."

This is a good example of the style of the day. Dr. Battey seems to have had a premonition that in spite of his good intentions and the addition he had made to surgical knowledge, "snatching" the ovary from its appointed seat in a young woman was not the wisest thing to do. It has taken 50 years and the

growth of knowledge in endocrinology for the harm of this procedure to be realized. In recent years, the profession, through its hospitals by-laws, has curbed the free removal of the reproductive organs.

The first hospitals were established originally only for the care of seamen and paupers. As early as 1789, the legislature appointed a commission to establish a Seaman's Hospital and Poor House. Dr. James Ewell, the author of the *Mariners Overseer's Medical Companion* was a member of the commission. He was a college trained physician, one of several invited here at about that time by businessmen interested in the health and growth of the city. He was active in promoting lotteries to raise funds, and the city appropriated \$3,000. The hospital was built at its present site in 1819. It had taken 30 years and \$30,000 to build it. This became the Savannah Hospital in 1872 and the Warren A. Candler Hospital in 1931. It has been in continuous operation since its opening.

As late as 1900, the majority of private patients were treated at home. Almost all babies were delivered at home, and an appendix or tonsils might be removed from a patient on the kitchen table. Laboratory tests, X-rays, anaesthesia, aseptic technique, and intravenous and intramuscular medication have made hospitalization a necessary part of diagnosis and care. Patient acceptance of hospitalization is very recent and is not even now complete in the geriatric and Negro population. Hospital and "sick" insurance have helped progress in this direction. One hundred years ago the possibility of such insurance was not dreamed of. The hospital room cost \$12 a week including drugs, except wine. Aside from the difference in the value of the dollar then and now, the cost of modern equipment makes the hospital bill to the patient today something to be reckoned with and "insurance" is the present solution. If only everyone carried enough!

There are many more changes which medical care in Savannah must encompass. In Savannah, as in most communities, study is being made for wider services to the geriatric, the handicapped, the medically indigent, the chronically ill, and those who must or can be cared for in the home.

Through the years medical knowledge and medical techniques have vastly changed and improved—doctors and their ethics are fundamentally the same. In conclusion, I want to reprint the *Code of Ethics* set up by our Georgia Medical Society in 1821. One of our members, Dr. Richard Arnold, was a member of the Committee on Ethics at the founding of the A.M.A. in 1847. An A.M.A. reprint as late as 1947 encompasses the same principles, but they are not as clearly put.

the patient, or his friends, unless the attending Physician be requested to name some one of his brethren.

5. No discussion on the nature of the disease, or on the plan of treatment, is to be entered on in the presence of the patient. When consultations take place, the greatest candour, respect and liberality, consistent with the welfare of the patient, should exist between the parties.—The Physician first employed should supply the medicines, whenever they are requisite.

6. The attending Physician is to give the necessary directions, and follow the treatment towards the patient agreed upon in consultation.

7. The Physician called in to consult, is not to interfere with the practice of the attending Physician, in his absence, unless he be out of town, or the emergency of symptoms render it necessary.

8. Visits during consultations should be together— if one does not arrive in time, the other should wait 15 minutes, before he sees the patient; after which time, he shall not be considered as having offended against Medical Ethics, if he either prescribes for the patient, or withdraws.

9. If the consulting Physicians cannot agree as to the treatment of the patient, the choice of the Practitioner devolves upon the patient, or his friends; and no offence is to be taken by the retiring party.

10. No Member is at liberty to consult with a Quack; inasmuch, as he would prop and support a character which he condemns—deprive his medical brethren of the advantages of their professional education, and degrade himself by mixing with ignorant and unprincipled pretenders.

11. The attendance of one Practitioner for another, in case of his ill health, should be gratuitous, even

3

where it may have been continued for a considerable length of time, and attended with considerable trouble.

12. No Practitioner of medicine, or any of his family, is to be charged by a brother for attendance. On the contrary, he is to be visited freely and cheerfully, as long as may be necessary. When a Physician quits practice, he must expect to be charged, both for himself and family.

13. In urgent calls to visit the patient of another, under medical treatment, the Physician so called in, shall consider his services rendered in behalf of his brother, and make it a matter of duty to vary the treatment as little as the circumstances of the case will allow. It shall be his duty, also, to give information of it, by letter or otherwise, as soon as possible.

14. In cases of accident, attended with fracture, the alarm and anxiety of the friends often induces them to send in different directions for medical or surgical assistance. No gentleman should withhold his aid, if it be possible for him to attend, on such an occasion.—It is a gratification to be useful; but he should withdraw as soon as the family Physician arrives; and consider his services as a gratuity to his brother Practitioner. Where there is no regular attendant or family Physician, the first who arrives should be considered the attending Physician.

15. Should any Member of any Medical Society, or Association, challenge any other to fight a duel, on a professional quarrel, the challenger and acceptor shall be both expelled.

16. It is necessary that the *Fee Bill* be uniform—the charges being made to suit all circumstances; and that every brother of the profession be governed by it alone. Diversity of charges has an effect upon the public mind, unfavourable to the dignity and integrity of the profession.

A SYSTEM

MEDICAL ETHICS,

ADOPTED BY

The Georgia Medical Society,

ON THE FOURTH DAY OF FEBRUARY, 1821,

FOR REGULATING

The Conduct of the Members of that Society.

ALSO

RECOMMENDED TO THE ATTENTION OF OTHER

Gentlemen of the Medical Profession, in Savannah,

NOT BEING MEMBERS OF THE GEORGIA MEDICAL SOCIETY.

Savannah:

PRINTED BY HENRY P. RUSSELL.
1822.

A SYSTEM

OF

MEDICAL ETHICS, &c.

1. The Medical Gentlemen of all places, are considered as the guardians of each others' professional honor. No circumstances, therefore, are to be revealed out of Societies or Associations, calculated to injure the reputation of a Member, unless it be deemed necessary by the Society,

2. Interference in a case under the charge of another, should be carefully avoided. No unnecessary enquiries should be made, advice nor hints given, nor any thing said or done, which may, directly or indirectly, tend to weaken the confidence or respect, due to the Physician employed, unless humanity require it. In this case, it becomes his duty, in a respectful and confidential manner, to suggest his apprehensions to the attending Physician; and, if this be not sufficient, to apply next to the family.

3. If a Physician is called to the patient of another, a consultation with him should be proposed, though he may have discontinued his visits. If a consultation be declined by either party, it is best, even then, for the Physician last called in, to converse candidly and freely with his predecessor, on the nature of the case, and to approve his practice, as far as probity and truth will permit. Want of success being not always proof of want of skill, neither should be backward:—the Patient will be benefited, by his symptoms and previous treatment being fairly understood, and a good understanding preserved between the Practitioners.

4. The choice of a Physician, when necessary to call in one or more, to consult, is always to be left to

Surgical Aspects of Polyps of the Colon

EDWARD S. JUDD, M.D., Rochester, Minnesota

POLYPS OF THE COLON have aroused a good deal of interest on the part of clinicians, pathologists, and surgeons for many years. For a time there was considerable argument about the exact life history of an individual polyp, some authorities holding that all of them become malignant sooner or later, others refusing to admit this. It is no longer argued that the colon capable of producing polyps is a very suspicious type of colon; it is agreed that whether any given polyp is of urgent importance or not, the surgeon is responsible for making it quite clear to the patient that a potentially dangerous lesion has been discovered.

It would appear that polyps of the colon may take different forms and that a variety of specimens may be exhibited in the same colon. Whether the single, isolated polyp represents an entirely different disease from that seen where scattered polyps are visualized, and whether the two of these are to be sharply distinguished from "familial multiple polyps," are questions that remain to be settled. However, with the tremendous strides that have been made in intestinal surgery, there is now a great field for prophylactic treatment which can be carried out at an extremely low risk. Full-blown cancer of the colon has been the subject of considerable discussion of late, but we, as surgeons, should be even more ready to discuss the prevention of cancer of the colon. With the modern adjuncts to surgery, much improvement is now noted in the method of handling these patients, and this constitutes a distinct advance in the field of cancer surgery in general.

The Isolated Polyp

David¹, in 1934, argued against the theory that an adenomatous polyp of the colon possesses a malignant potential. He pointed out that many such polyps are demonstrated at routine necropsy. He said further that polyps are seen in children, whereas cancer of the colon in a child is extremely rare. A little later, Swinton and Warren², in reporting the results of a study of 826 patients exhibiting cancer of the colon, were convinced that the cancer originated

in a polyp in 14 per cent of these patients. Since that time many authorities have agreed that polyps of the colon, if not immediately dangerous, are all at least potentially dangerous, and now there seems to be little real argument to the contrary.

DeMuth and co-workers³, a few years ago, stressed again the great need for careful search for other polyps when one polyp had been located, and most present-day authorities agree that such a search should be made. All surgeons interested in this type of work have been struck by the incidental finding of "sentinel" polyps in the segment of colon that has been resected for full-blown cancer. There has never been any argument about wide resection for the cancer, but there has been a striking lack of emphasis on aggressive treatment for the isolated polyp.

Transcolonic Excision—Formerly it was routine simply to open the colon and remove a pedunculated polyp, with perhaps too little emphasis being placed on the exact microscopic diagnosis of the specimen removed. Carlisle and I⁴ attempted to determine the fate of those patients who had undergone nothing more radical than transcolonic excision of a polyp or polyps. The study included only those patients who had been operated upon at least five years previously. We found that 98 per cent of the patients returned for their follow-up examinations during the first two years and that 95 per cent returned during the first five years after operation. In this series of 246 patients, 70 per cent of the cases occurred in the fifth, sixth, and seventh decades of life, as we had predicted. The pathologist had classified the polyps carefully and we were able to present our material under the following headings: (1) adenomatous polyp, (2) adenomatous polyp with low-grade noninvasive carcinoma (carcinoma in situ), (3) adenomatous polyp with low-grade invasive carcinoma, and (4) carcinomatous polyp.

No further polyps were found in 72 per cent of the patients. However, 15 per cent of the patients did exhibit additional polyps that required abdominal operation, and the remaining 13 per cent exhibited polyps that could be fulgurated proctoscopically. It is possible that the latter were new polyps, as they were then well within the reach of the proctoscope,

¹Read at the meeting of the Medical Association of Georgia, Atlanta, Georgia, May 14, 1936.

²From the Section of Surgery, Mayo Clinic and Mayo Foundation. The Mayo Foundation, Rochester, Minnesota, is a part of the Graduate School of the University of Minnesota.

which had not been the case at the time of the first treatment. Of the recurrent polyps exhibiting definite clinical adenocarcinoma, 50 per cent were in the group in which the original polyp had been found to exhibit definite evidence of malignant invasion of the pedicle. The location of the original polyp seemed important but perhaps only because the sigmoid colon and the descending colon are so much more prone to be the site of polyps in the first place. In 12 patients the proctologist visualized the polyp easily but recognized at once that an invasive process was at hand and hence called the surgeon for more radical treatment than could be afforded through the proctoscope. Although the number of polyps found in the proximal portion of the colon was relatively small, the number of recurrences there was relatively large, and review of the original specimens revealed a more malignant process from the very start.

The number of polyps present at the time of the first admission appeared to be important. Whereas 60 per cent of the patients presented single, isolated polyps, 15 per cent presented three or more polyps at the time of the original examination. Of the patients in whom recurrent disease developed, 25 per cent originally exhibited three or more polyps; in fact, we found that when four or more polyps were present on the first visit the chance of further polypoid disease was greater than when only a single polyp was present.

Certain discrepancies immediately suggest themselves. Thus, the patient with multiple polyps was kept under much closer scrutiny subsequently, and it is always possible, of course, that one or more additional polyps could have been overlooked the first time and listed later as recurrent lesions or as evidence of further polypoid disease.

The time required for recurrent polypoid disease to become evident was extremely variable. The shortest time appeared to be 10 months and the longest time was more than 13 years after transcolonic excision. Of the 15 definitely malignant lesions that recurred, four made their appearance in less than 12 months, but, on the other hand, one of the others required 13 years. The average time elapsed before recurrence was proved was 4.7 years.

We thought it imperative to determine the risk entailed in the transcolonic excision of polyps during the period studied. We found that only two of the 246 patients died in the hospital, the first death occurring in 1920 and the second in 1941. Both deaths were caused by peritonitis. Hence, it can be seen that the surgical risk is very low.

We determined the cause of death in those patients followed after their operations at the clinic and found that 10 patients had died in the group

in which "recurrent polypoid disease" developed above the level of the rectosigmoid. All of these deaths apparently were related to the original disease; seven were proved to be due to carcinoma of the colon, and two probably due to carcinoma, but the tenth apparently was not due to this complication. Of these 10 people, only five were living five years after their transcolonic operations. We concluded that if only a single, isolated, pedunculated polyp can be found and if that polyp is a benign adenoma, mere transcolonic polypectomy will probably suffice. However, as mentioned previously, 28 per cent of the patients did exhibit additional polyps somewhere in the colon at a later date, and definite clinical carcinoma of the colon was proved subsequently in 15 patients.

Current Practice—As a result of this study, my colleagues and I have become much more aggressive in cases of this type. We still remove the benign, adenomatous, pedunculated polyp by local excision. For the sessile polyp we are inclined to do a wide removal, whether the pathologist demonstrates actual malignancy or not. If any malignant features are found in the stalk, we now carry out a formal segmental resection of the bowel, feeling that microscopic evidence of malignant invasion means that transcolonic polypectomy will be inadequate. We noted that the great majority of polyps occur in the left half of the colon, and the incidence of recurrent disease rate in that region has led us to carry out left hemicolectomy with very little hesitation if several polyps are demonstrated in that location. We believe that ridding the patient of this potentially dangerous portion of the colon is doing him a distinct favor, and we can do this with little risk under modern-day methods.

The problem patient at present is the one who exhibits one or two polyps in the right portion of the colon, perhaps one in the transverse portion, and one in the left portion. Probably these patients should be looked upon as representing merely one variant of "multiple polyposis" and should be subjected to subtotal colectomy without hesitation. Here is a great possibility for prophylactic surgery. The roentgenologist has developed to the utmost his ability to detect these polyps, but nevertheless he continues attempts to improve upon this record.

For several years we have made it a routine matter to have a sterile proctoscope available in the operating room; with it one can inspect the interior of the colon in both directions through a small incision in the bowel wall. With some practice, one learns to detect further polypoid disease, which may be treated surgically at once, thereby decreasing the risk of overlooking a lesion that may demand a second abdominal operation in the near future.

Familial Multiple Polyposis

The condition indicated by this title fortunately is quite rare. However, when it appears it poses a clear-cut problem, as it is now agreed that all persons with the condition will subsequently have carcinoma of the colon unless they are treated early. In contrast to the bowel in cases of isolated polyp or multiple polyps, the bowel in this condition is literally studded with thousands of polyps. It is beyond the scope of this paper to delve into the genetic features of the disease. It suffices to say that the tendency for it to appear in families is striking. Children of parents known to have the disease should not be considered safe until well after puberty. In other words, a negative result on x-ray examination of the colon of a child means nothing, as many of the cases are not fully developed until late adult life.

In earlier years, surgeons were well aware that the colon must be removed in the treatment of familial multiple polyposis. Because of the high morbidity rate and the great operative risk, the operation necessarily was divided into multiple stages. It was unusual to see a patient who had survived all stages and who was rid of his entire colon and rectum. Many of the patients became discouraged and failed to return for definitive therapy, being left with an assortment of stomas and varying lengths of colon containing the potentially malignant tumors. This naturally frightened the children in such a family, so that they became secretive about symptoms that may have developed. Among the symptoms is anemia, which is common because of constant loss of blood through the stool. This, alone, makes some type of therapy mandatory.

Single-stage Resection—After the widespread adoption of more modern methods for the preparation of patients who are to undergo definitive resection for diseases of the colon, Black and Hansbro⁵ summarized the Mayo Clinic experience and presented a small series of patients with familial polyposis who had been treated by a single-stage method. Since that time our experience with a considerable series of cases has led to certain opinions as to the proper method of approach. Whereas the multiple-stage operation left the patient with perhaps a side-to-side ileosigmoidostomy, proximal retrograde colonic stomas, and relatively inaccessible lengths of colon still bearing dangerous polyps, the more modern procedure lessens some of these difficulties.

Stated briefly, the one-stage operation is carried out through a long left-rectus incision. The terminal part of the ileum and the entire abdominal portion of the colon are removed down to the lower part of

the sigmoid. By the removal of only a conservative amount of ileum and the removal of only the part of the sigmoid colon that is above the level of the superior hemorrhoidal vessels, diarrhea has been avoided for most patients. When carcinoma is not already present, large amounts of mesentery may be preserved to facilitate the reperitonealization of the abdomen, leading to a smoother convalescence. If carcinoma is known to be present, the classic radical resection should be done immediately. My colleagues and I have emphasized end-to-end ileo-sigmoidostomy for very specific reasons. It seems to be a simpler and more physiologic procedure and leaves no "blind" stumps to produce possible complications. More important, it leaves a situation in which the proctologist knows exactly what he is looking at later and can fulgurate the rectal polyps and be certain that the condition is corrected in the remaining portion of the colon.

Incidentally, we are strongly opposed to proctoscopic fulguration first, to be followed by resection later, for several reasons: The surgeon who undertakes resection of the sigmoid in a freshly fulgurated region may be working in a dangerous field. In addition, the proctologist may have spent a week or more fulgurating a few inches of the left half of the colon which could be easily included in the surgeon's resection. Then, too, we must never forget that postoperative deaths, though few in number, do occur, and hence it seems illogical to take the chance of first putting the patient through the prolonged, expensive fulguration program, only to have him fail to survive the major operation at a later date.

In our experience, the patient may have eight or 10 bowel movements a day during the postoperative stay in the hospital. The number quickly decreases to about five a day for the next month or so, and after that it is a rare patient who has more than two a day. There is no nutritional disturbance. As soon as the wound has healed completely the proctologist starts destruction of the remaining polyps. This may require many trips to the office, but sooner or later he finds that the bowel is free of polyps. Then a rigid program of follow-up is arranged because there is a tendency for the development of polyps to continue, and they must be destroyed when they appear. In a significant series of patients who have been followed successfully in this way for some five to ten years the results have been most gratifying.

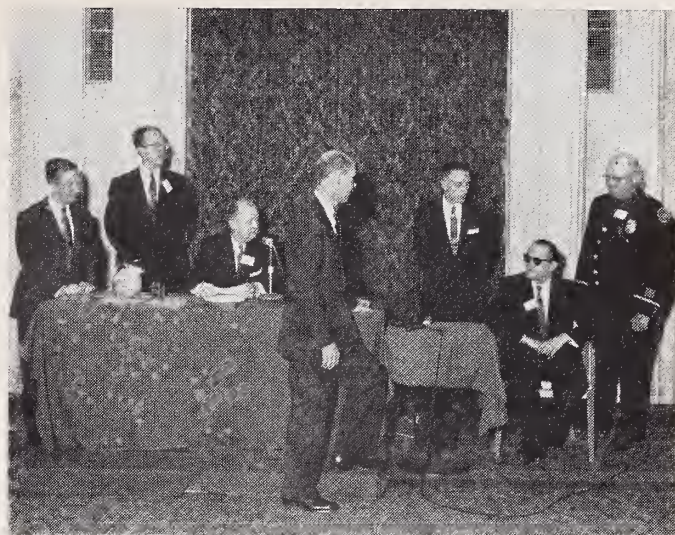
The obvious advantage of a single-stage operation is too striking to require much comment. The follow-up is surprisingly easy. The patients have witnessed what has happened in older members of

Medicolegal Symposium Held in Atlanta

ON MARCH 15 AND 16, 1957, the Law Department and Committee on Medicolegal Problems of the American Medical Association sponsored a Medicolegal Symposium at the Atlanta Biltmore Hotel; more than 300 physicians and lawyers from the Southeast attended. Mr. C. Joseph Stetler, Chicago, head of the AMA Law Department, was conference chairman. The program opened with a short address by David B. Allman, president-elect of the AMA, followed by words of welcome from representatives of the American Bar Association, Medical Association of Georgia, and Georgia Bar Association. Herman A. Heise, Milwaukee, Wisconsin, spoke on "Chemical Tests for Intoxication—Scientific Background and Public Acceptance". Following his talk, a demonstration was given of a trial of a drunken driving case. (Participants are pictured at right.)

On Saturday morning, there was a panel discussion of "Trauma and Cancer", and the audience was invited to address questions to the panel for answer.

"Medical Expert Testimony" was the subject discussed by Irving Goldstein of Chicago; his talk was followed by a film entitled, "The Medical Witness". With "The Medical Witness", the American Medical Association and the American Bar Association have joined forces for the first time to present a series of educational films dealing with the professional relationships of doctors and lawyers. This is a 34-minute black and white film, 16 mm., which depicts right and wrong methods of presenting medical testimony by re-enacting the trial of a personal injury case. For those of you who could not participate in



Left to right: Capt. Robert F. Borkenstein, Indiana State Police; Mr. William J. McAuliffe, Mr. C. Joseph Stetler, and Mr. Edwin J. Holman, all of the AMA Law Department; William W. Bolton, Associate Director, AMA Bureau of Health Education; Mr. George B. Larson, Assistant Director, AMA Bureau of Exhibits; and Sgt. G. Herbert Williams, Atlanta Police Department.

the recent symposium, medical societies may arrange for the showing of the movie by writing to the Film Library, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois, or to the William S. Merrell Company, Cincinnati 15, Ohio, producers of the film as a service to the medical and legal professions.

There is also a pamphlet on "Medical Expert Testimony" available to physicians from the same source.

Symposiums similar to the one held in Atlanta were held in Denver and Philadelphia later in March.

Surgical Aspects of Polyps of the Colon (cont'd)

their families who had the same trouble and failed to get rid of their disease; as a result they always appear on schedule and undergo fulguration treatment readily, and nowhere do we find a more gratifying group.

It may be argued that retention of the rectum is poor policy in the prophylaxis of cancer; in fact, several authorities are outspoken in their condemnation of this policy. We admit that two of our patients later had to undergo removal of the rectum, but we think that this is a small price to pay for several hundred patients who have done well without that sacrifice. Fortunately, both of those requiring the second operation have also done well. We are ever mindful that the necessity for existence with an ileac stoma is something to be avoided if it can be avoided safely. We also are aware of the fact that if cancer is already present in the rectum when we first see the patient, we would be doing a great in-


justice if we attempted to save the rectum. This type of case is eliminated from present consideration.

Perhaps nowhere is the importance of cancer prophylaxis so obvious as in the field of familial multiple polyposis.

Mayo Clinic

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Aspects of Chest Pathology Affecting Anesthesia

C. R. STEPHEN, M.D., M. BOURGEOIS-GAVARDIN, M.D., and L. W. FABIAN, M.D., Durham, North Carolina

ADMINISTRATION OF ANESTHESIA has progressed considerably from the stage where it was felt that the measure of success could be gauged by the degree of immobility of the patient. Today a satisfactory state of anesthesia certainly means adequate operating conditions, but it implies equally well the preservation of the "milieu interieur" as close to the physiological normal as possible. The normal physiological status may be upset by the impact of toxic anesthetic drugs or their technique of administration. If pathology already existing in the patient involves particularly the lungs or heart, the task and aims of the anesthesiologist become doubly complicated. The purpose of this discussion is to outline how some aspects of chest pathology may influence the conduct of anesthesia.

Pulmonary Diseases

A disease process in the lungs sooner or later interferes with normal gaseous exchange across the alveolar membranes in both directions. Oxygenation of the blood becomes more difficult, and elimination of carbon dioxide is impaired. The conscious patient under stress will increase respiratory exchange in an effort to maintain the status quo relating to oxygenation and carbon dioxide tension. The narcotized patient is handicapped. The state of anesthesia obtunds the normal reflex responses, and furthermore in many cases anesthetic drugs are employed which depress the respiratory center or paralyze the muscles of respiration. The net result is a gross dysfunction of pulmonary dynamics. Figure 1 exemplifies how the pH, carbon dioxide tension, and arterial oxygen saturation may be altered by anesthesia and operation in a "normal" patient under stress. One can realize how complicated the picture may become if pulmonary disease is present and if thoracotomy is being performed for its surgical correction. Pulmonary pathology of particular concern to the anesthesiologist may be considered as follows:

1) *Bronchiectasis, lung abscess, and tuberculous lesions associated with abundant secretions.* Abnor-

mal secretions in the terminal bronchioles and alveolar sacs prevent normal gaseous exchange. In diseases such as bronchiectasis, permanent histological changes may develop also in the alveolar membranes.

Preoperatively, these patients may be helped by adequately performed and repeated postural drainage. The administration of antibiotics, particularly by means of aerosols, for 10 days prior to operation, may reduce secretions remarkably. In severe cases bronchoscopy, with aspiration of secretions under direct vision, may be necessary.

Operation is best performed in the late morning so as to allow patients to cough up or drain secretions which have accumulated during the night. When the secretions are coming predominantly from one lung, the employment of a Carlen's endotracheal catheter during anesthesia will prevent contamination of the other lung. Frequent suction and aspiration of the tracheobronchial tree is necessary to maintain adequate gaseous exchange to and from the pulmonary capillaries. The choice of anesthetic drugs in such cases is not nearly as important as the maintenance of adequate alveolar ventilation with gases which contain plenty of oxygen. In intrathoracic cases, such ventilation can be assured only by con-

B., R.	A 18741			16 September 55	
	Pelvic Evisceration				
	pH	p CO ₂	O ₂ Sat. %	K	
8:10	7.32	55.5	78.0	4.3	Spon.
9:10	7.40	40.7	89.0	4.7	Cont. In Abdomen
10:10	7.32	50.5	78.0	4.2	Cont.
11:15	7.42	38.6	91.0	4.3	Cont.
12:30	7.32	50.5	77.0	4.1	Asst.
1:30	7.29	56.3	40.0	4.5	Spon.
2:20	7.35	50.7	82.0	4.0	Spon. Ether
2:50	7.50	30.5	100.0	4.6	O ₂ only Severe shock
Blood, 8,500 cc					

Figure 1

To show variation in pH, pCO₂ and O₂ values during a pelvic evisceration in a 52 year old female not suffering from pulmonary disease. Anesthetic drugs employed over a 7½ hour period were surital sodium, 1700 mg., meperidine, 175 mg., succinylcholine, 730 mg., nitrous oxide, oxygen, 75:25 and ether, 2 ounces.

From the Division of Anesthesia, Duke University Hospital and School of Medicine, Durham, N. C.
Presented at the Annual Session of the Medical Association of Georgia, May 13-16, 1956, Atlanta, Ga.

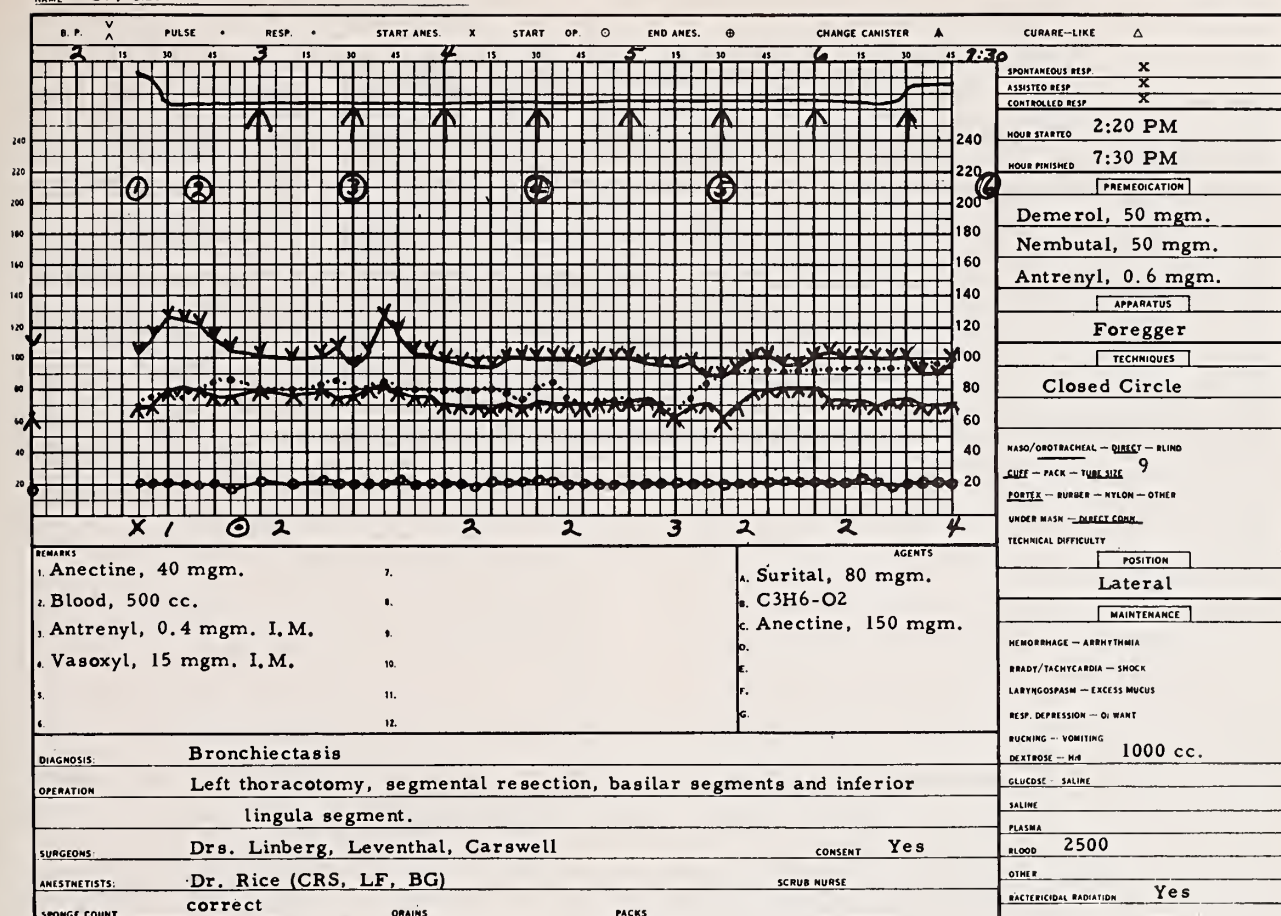


Figure 2A

A. Anesthetic record of 31 year old white female suffering from bilateral bronchiectasis. Operation: segmental resection left lower lobe. Anesthesia: surital sodium, 80 mg., C_3H_8 and succinylcholine, 150 mg. Respirations controlled throughout operation.

trolling properly the respirations of the patient, i.e., by assisting vigorously the voluntary efforts of the patient or by taking over completely tidal exchange, employing a manual or mechanical type of artificial respiration.

Postoperatively, if secretions persist or the tracheobronchial tree has not been suctioned adequately during surgery, frequent tracheal aspirations by means of urethral catheters or the bronchoscope are necessary to prevent severe hypoxia. In addition, adequate oxygen therapy is important. In severe cases where anoxia is persistent, there should be no hesitation in performing a tracheotomy. A tracheotomy permits frequent and relatively thorough aspiration of the tracheobronchial tree by nursing personnel and also reduces the dead space, thus allowing better alveolar ventilation.

Figure 2, A and B, shows the anesthetic record and arterial blood estimations of a 31-year-old white female patient with extensive bilateral bronchiectasis who had a segmental resection of the left lower lobe. Preoperatively, maximum breathing capacity was 44 per cent of normal, and pulmonary washout required 15 minutes (normal four to six minutes). During

C., M.	E 24831	February 15, 1956		
Left thoracotomy for bronchiectasis				
	<u>pH</u>	<u>pCO₂</u>	<u>O₂ Satn. %</u>	
2:20	7.39	43.4	97	Induction just begun Spon. resp.
2:40	7.35	48.8	100	Controlled resp. Extrapleural
3:30	7.36	43.2	100	Controlled resp. In chest
4:30	7.37	43.0	98	Controlled
5:30	7.37	40.7	100	Controlled
7:30	7.33	52.8	73	Extubated Spon. resp. Awake

Figure 2B

B. pH, pCO₂ and O₂ arterial estimations during operation.
N.B. trend towards acidosis and hypoxemia at end of operation
when on spontaneous respirations.

operation, high oxygen concentrations plus adequate, controlled respirations maintained normal blood values. Note hypoxia and trend towards acidosis at end of operation. Postoperatively, tracheotomy was done because of abundant secretions, hypoxia, and rising carbon dioxide tension.

2) *Pulmonary emphysema and fibrosis.* The patient with barrel-chest and minimal respiratory reserve is to be feared by the anesthesiologist. The low

DATE 7-16-54
AGE 62
NAME J. J.

ANESTHESIA RECORD DUKE HOSPITAL

UNIT NO A 2641
WARD McDowell

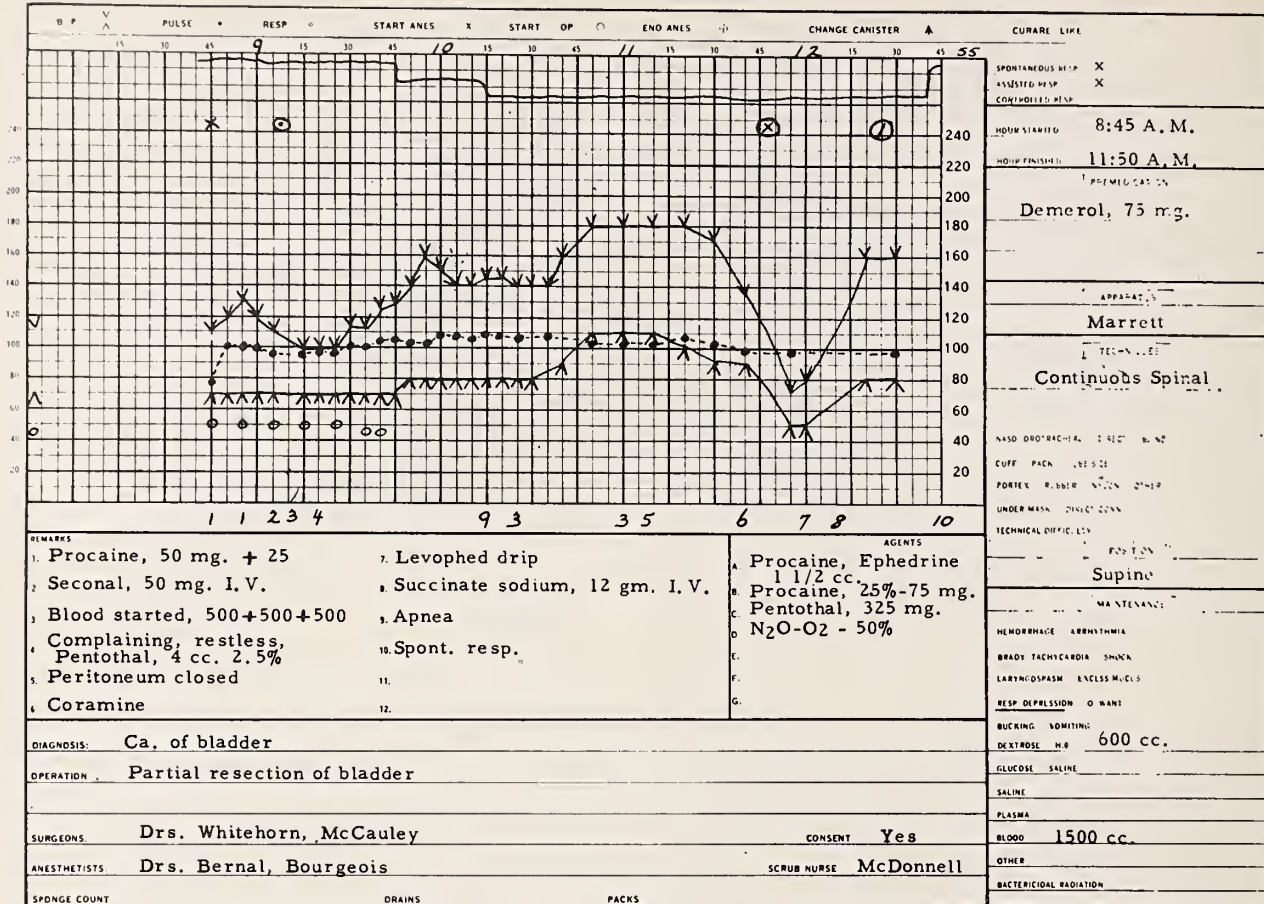


Figure 3A

A. Anesthetic record of 62 year old colored male undergoing partial resection of the bladder for carcinoma. Anesthesia: Continuous spinal followed by pentothal sodium and nitrous oxide-oxygen. Patient suffered from obstructive emphysema with chronic bronchitis and acute respiratory insufficiency.

arterial oxygen saturation and high carbon dioxide tension frequently present under normal conditions is evidence of inadequate alveolar function. Mixing of gases within the lung is difficult because of the increased residual air space. These patients live in a delicate state of compensation, and the balance may be disturbed with utmost ease.

Preoperatively, recent evidence suggests that positive pressure therapy may help to improve alveolar exchange and reduce the imbalance of oxygenation and carbon dioxide retention. Such measures are worth trying.

At the time of surgery, the precarious balance is upset least if spinal or regional analgesia is employed. If general anesthesia is necessary, the problem revolves about maintaining adequate oxygenation, while at the same time trying to prevent either excess washout or accumulation of carbon dioxide. Either extreme may be hazardous, although increase in carbon dioxide tension is probably the most dangerous. These requirements are attained best by limiting the oxygen inhaled to 25 per cent of the mixture being given and assisting or controlling respirations

J. J.	A 2641 Carcinoma Bladder			16 July 54
	pH	p CO ₂	K	
12:20	6.70	228.0	5.3	Apnea
1:15	6.60	256.5	5.9	Beginning Spon.
2:00	6.90	138.0	6.4	Adequate Spon.

Figure 3B

B. pH and pCO₂ tensions recorded following completion of operation and during period of apnea and unconsciousness.

as indicated to maintain normal ventilation of the lungs and thus elimination of carbon dioxide.

At the end of an operation under general anesthesia, difficulty may be encountered in establishing normal spontaneous respiratory exchange. This difficulty may be due to the fact that during the operation the patient has been better oxygenated than previously. His respiratory center, which had become accustomed to a degree of hypoxia, no longer is receiving activating stimuli through the carotid body. In the effort to establish adequate respirations, it is useful to dilute the inhaled oxygen with an inert gas such as helium. In this way the high oxygen concentration the patient may have been receiving can be reduced gradually. In the recovery room oxygen therapy must be controlled carefully. Excess oxygen-

ation will decrease respiratory exchange and allow accumulation of carbon dioxide within the blood, resulting in irrationality, somnolence, and carbon dioxide narcosis.

Case Report

The following case report is an extreme example of acid-base balance disturbance during anesthesia. J. J., a 62-year-old colored male, had acute respiratory insufficiency due to obstructive emphysema with chronic bronchitis. He showed generalized arteriosclerosis and cardiac enlargement, but was not in cardiac failure. He came into hospital because of symptoms associated with a carcinoma of the bladder. Hemoglobin on admission was 7.0 Grams, and this was raised to 11.0 Grams by repeated transfusions. The operation proposed was partial resection of the bladder. Because of his pulmonary pathology, it was elected to produce anesthesia by means of a continuous spinal. A satisfactory level of analgesia to D.9 was obtained with procaine, 75 mg. (Figure 3 A), and the operation was begun. When the abdomen was entered, exploration of the liver unexpectedly was done. This maneuver caused such distress to the patient that general anesthesia was initiated, using pentothal sodium and nitrous oxide-oxygen in equal amounts. Thirty minutes following induction of general anesthesia, spontaneous respirations became inadequate and manual assistance to respirations was begun. Gradually spontaneous respirations ceased completely and exchange was controlled entirely by the anesthetist. At the end of operation the patient had received over a period of two hours only 325 mg. pentothal sodium. However, no spontaneous respirations were present, and the patient was unconscious. Thirty minutes postoperatively, an arterial blood sample was withdrawn and showed severe acidosis (Figure 3 B). Beginning spontaneous respirations occurred about one hour later and adequate respirations were restored in two hours. Subsequent progress of the patient was satisfactory. This patient represents the severe upsets in respiratory physiology which can occur in the presence of emphysema during anesthesia.

3) *Asthma*. The chronic asthmatic patient who has a variable degree of emphysema associated with bronchiolar constriction is a challenging anesthetic problem. Preoperatively, specific bronchodilating drugs are of value, including those which can be given by aerosol inhalation.

Surgery is best performed under regional methods of analgesia if feasible. Marked anxiety on the part of the patient is a contraindication to such techniques, as fear may precipitate a severe paroxysm. When general anesthesia is necessary, drugs which produce bronchodilation should be chosen. Ether is the best, and asthma remains one of the few specific indications for the use of this drug in the adult. The parasympathomimetic drugs, cyclopropane and pentothal sodium, and the histamine-releasing curariform drugs are not recommended in these patients. The induction period of anesthesia is particularly difficult in asthmatic patients, as the irritant effects of

the ether vapor may intensify the spasm and decrease ventilation, thus producing hypoxia before the bronchodilating effects of the drug become active.

Postoperatively, the administration of oxygen in moderate concentrations and in an atmosphere of high humidity maintains arterial oxygen saturation at normal levels and aids in preventing the formation of viscid secretions. The addition of detergents to the humidifying source also is helpful in thinning secretions.

Cardiac Pathology

The anesthesiologist can exercise a considerable control over the ventilation of the patient during operation. This control does not extend in the same degree to the function of the heart. Errors of omission or commission often can be rectified in the respiratory system when recognized, but not always in the vascular system. Improperly conducted anesthesia may depress the function of the myocardium, interfere with venous return to the heart and thus decrease cardiac output, or diminish coronary flow, thus leading to myocardial anoxia. When cardiac pathology exists in the patient, it behooves the anesthetist to take special precautions to avoid any one of these several dysfunctions.

Patients with mitral stenosis and other valvular lesions surgically remediable often come to operation with the history of having recently been in cardiac failure. They represent the group of patients who have little cardiac reserve, whose activities are strictly limited by their cardiac pathology. Preoperatively, myocardial function may be improved by digitalization and, if ventricular irritability is suspected, administration of quinidine may be wise. A regimen directed towards dehydration helps in the days following operation. Outstanding in the anesthetic management of these patients are the minimal concentrations of drugs which are tolerated. The heavy-handed anesthesiologist invites trouble in these procedures. It matters not so much what drugs are employed, so long as they are used in minimal quantities. "Normal" quantities of ultra-short-acting barbiturates or ether will depress the myocardium directly, with the result that cardiac output decreases, as recognized by hypotension and narrowed pulse pressure. Preservation of normal arterial oxygenation and carbon dioxide tension are important, and such values can be maintained in the open chest only by actively assisting or controlling the ventilation of the patient. Controlling the respirations completely provides a quieter field and therefore more satisfactory operating conditions for the surgeon. Ventilation must be provided in a proper manner, using only one-third of the respiratory cycle for the inspiratory phase. In this way venous return to the heart will be

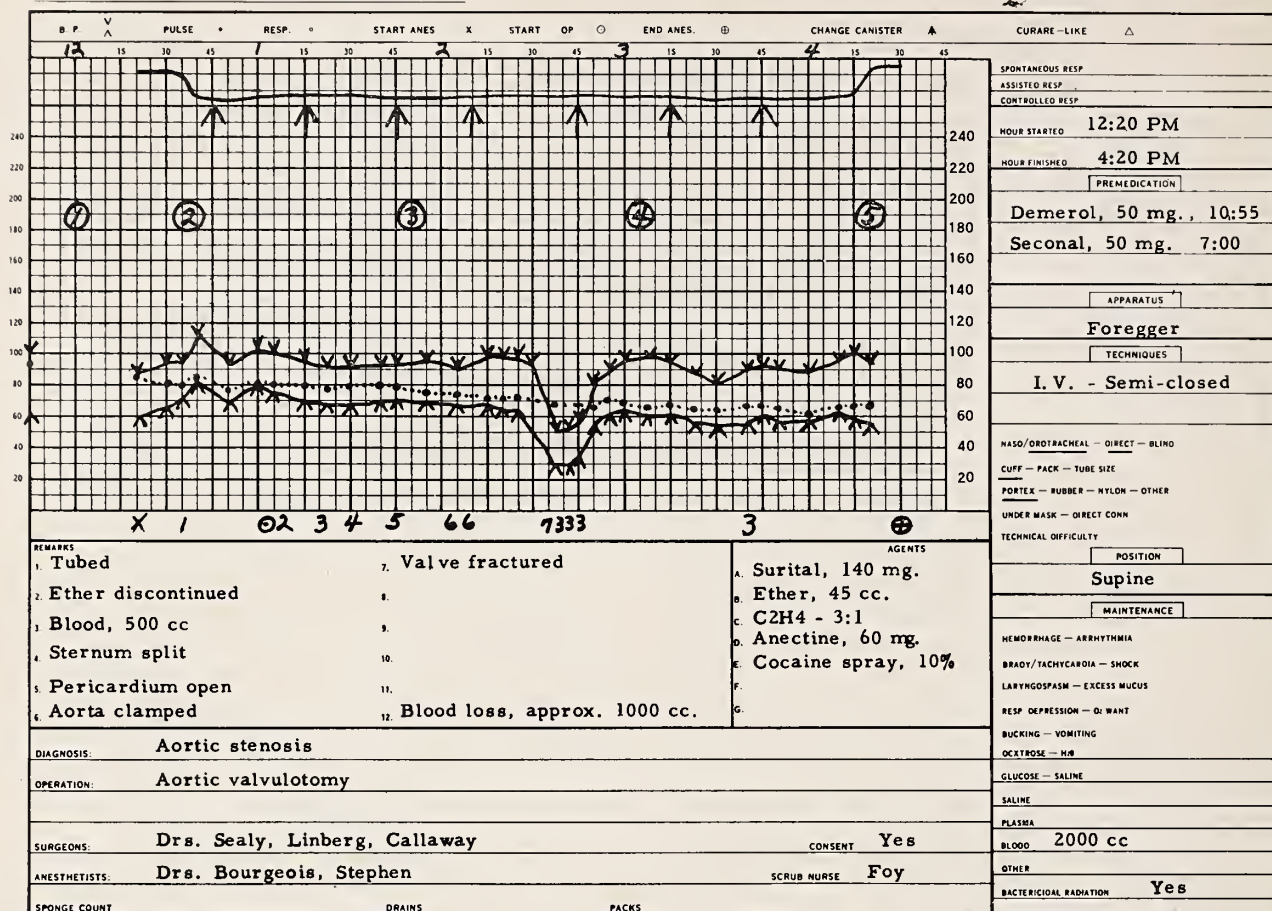


Figure 4A

A. Anesthetic record of 52 year old white male undergoing operation for aortic stenosis. History of shortness of breath for two years. Electrocardiogram showed ventricular premature contractions, left ventricular strain and hypertrophy. Convalescence uneventful.

adequate, and output will not be jeopardized. If the inspiratory or positive phase of the respiratory cycle is prolonged during assisted or controlled respiration, venous return to the heart will in all likelihood be impaired. Figure 4 (A and B) shows the anesthetic record and arterial blood findings in a 52-year-old white male undergoing an aortic valvulotomy. Light planes of anesthesia employing ethylene, traces of ether, and succinylcholine, along with properly controlled respiration minimize the risk to the patient.

Coronary insufficiency is a condition which is difficult to diagnose in many patients. However, in geriatric patients who are seen more frequently each year in operating rooms, coronary sclerosis is a common accompaniment of generalized arteriosclerotic hypertensive vascular disease. Adequate coronary blood flow, and hence oxygenation of the myocardium, can be assured only by preserving the mean arterial blood pressure during operation. Anesthesia must be administered in such a way that a relative hypotension does not occur for any sustained period. Oxygenation of the arterial blood is important, but must be accompanied by maintenance of coronary

H., W.	E 24424				January 24, 1956
Exploration anterior mediastinum. Aortic valvulotomy.					
	<u>pH</u>	<u>pCO₂</u>	<u>K</u>	<u>O₂ Sat. %</u>	
12:00	7.41	42.3	4.7	93	Control Awake
12:40	7.30	52.2	4.5	87	During Intubation
1:50	6.97	95.2	4.1	96	Controlled Exploring
3:05	7.54	26.8	4.4	100	Aorta cracked Blood loss + + Controlled
4:20	7.38	40.9	4.1	100	Spon. resp. Awake

Figure 4B

B. pH, pCO₂, potassium and arterial determinations during four hour procedure. N.B. acidosis during exploration phase.

flow. When spinal analgesia is chosen for such patients, the associated sympathetic blockade may produce significant hypotension. In the patient with coronary sclerosis this situation can be dangerous and can be rectified by the administration of vasopressor drugs, preferably by means of a dilute intravenous drip which can be regulated from moment to moment. When general anesthesia is chosen, the patient should be kept in light planes and muscular

DATE 9-19-55
AGE 75
NAME M., J.

ANESTHESIA RECORD DUKE HOSPITAL

UNIT NO E 15502
WARD McDowell

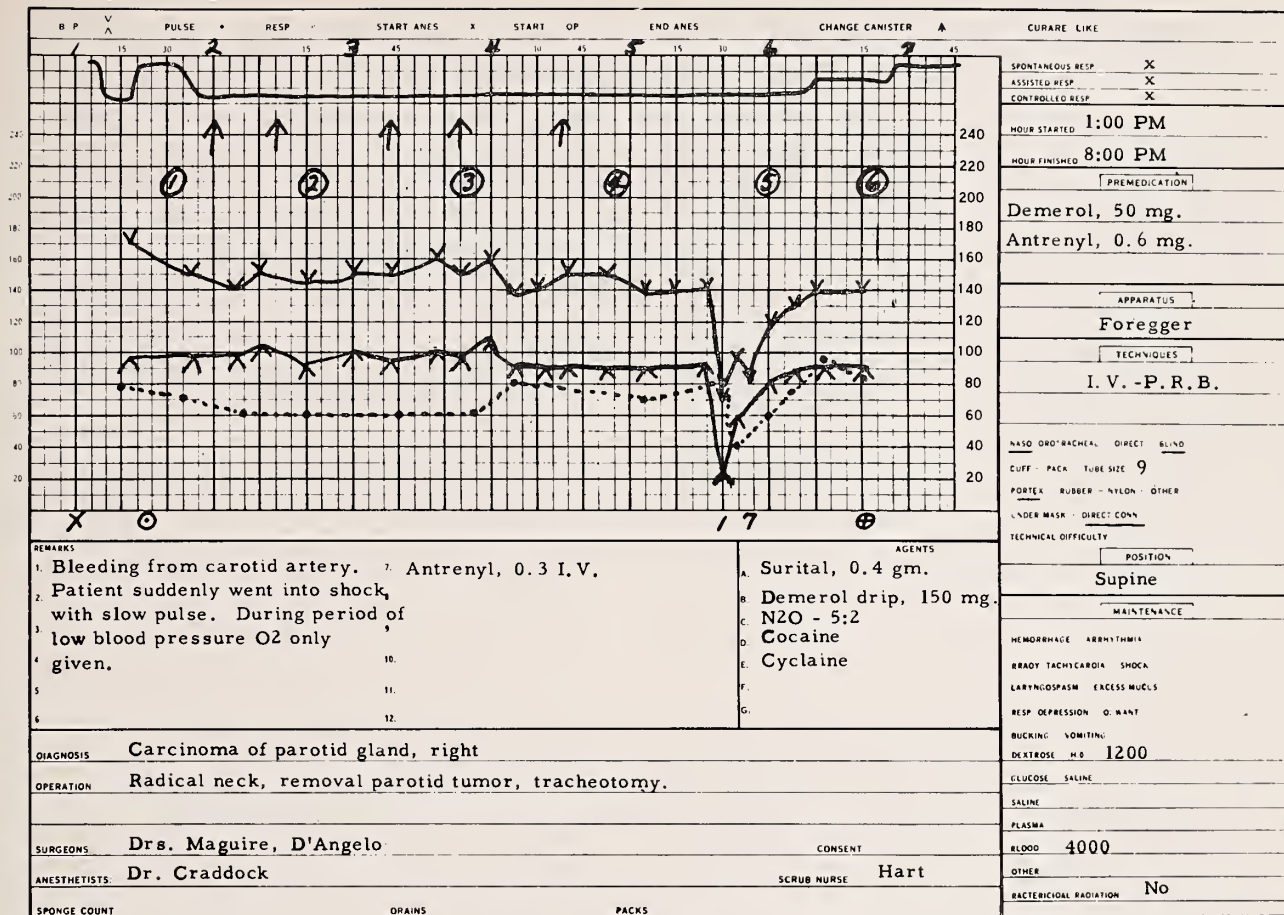


Figure 5A

A. Anesthetic record of 75 year old white male undergoing a removal of parotid tumor and radical neck dissection for carcinoma. Anesthesia: surital sodium, 400 mg., Demerol, 150 mg. and nitrous oxide-oxygen, 70:30, with controlled and assisted respirations. N.B. preservation of blood pressure except for one short period. Postoperative course satisfactory.

relaxation provided by muscle relaxant drugs rather than deep planes of anesthesia. Any sudden hypotension should be diagnosed and corrected immediately.

Figure 5 (A and B) shows the anesthetic record and arterial blood findings in a 75-year-old white male who came to operation for radical removal of a carcinoma of the parotid gland and radical neck dissection. Preoperative blood pressure was 170/95. The heart was enlarged and electrocardiogram showed a first degree auriculo-ventricular block, left ventricular hypertrophy, and left ventricular ischemia. It was concluded that this patient had hypertensive disease probably associated with coronary insufficiency. This patient was intubated blindly through the nose while awake, after thorough topical anesthetization of the nose, pharynx, and tracheo-bronchial tree (transtracheal). Anesthesia was maintained in light planes with nitrous oxide and oxygen and slow dilute Demerol® drip. The respirations of the patient were controlled to maintain adequate oxygenation and prevent carbon dioxide retention.

M., J.	E 15502			19 September 55
Radical Neck Dissection				
	<u>pH</u>	<u>p CO₂</u>	<u>O₂ Sat. %</u>	
1:45	7.42	40.8	78.0	Spon.
2:45	7.42	38.8	100.0	Cont.
3:50	7.42	45.7	96.0	Cont.
4:55	7.50	38.0	96.0	Cont.
6:00	7.50	36.2	100.0	Cont. B. P. 70/50 O ₂ only
6:45	7.42	45.2	99.0	Asst. Closing

Figure 5B

B. pH, pCO₂ and arterial oxygen values during seven hour operation.

Blood pressure was maintained at safe levels except for one short period when hemorrhage was associated with bradycardia and sudden hypotension. These alterations were believed to be due to a combination of rapid blood loss and excessive vagal stimulation in the region of the carotid sinus. The situation was corrected quickly by replacement of blood and administration intravenously of an anti-cholinergic drug, Antrenyl®. The postoperative course was benign.

Within the last two to three years operations for

1956 Poliomyelitis Surveillance Program

THE MAJOR CONCLUSIONS that can be drawn from a review of the Poliomyelitis Surveillance Program conducted throughout the United States during 1956 are:

1. The poliomyelitis vaccine used during 1956 has been safe.
2. The vaccine has been effective in preventing the paralytic form of the disease.

The Poliomyelitis Surveillance Program was initiated by the Communicable Disease Center in Atlanta, Georgia, in 1955 and has continued in operation throughout 1956. More than 40 Epidemic Intelligence Service officers and other professional staff at the Center have devoted their primary attention this year to studying the effects of the poliomyelitis vaccination program and to developing additional, current knowledge about poliomyelitis through the mutual exchange of information with state and local health departments and with more than two dozen virus research laboratories.

Although the rapid and widespread use of the vaccine during 1956 made it impossible to conduct controlled studies of effectiveness, comparable to those conducted in 1954 and 1955, all the available data for 1956 support the earlier findings. These data include:

1. Total incidence of poliomyelitis (only 15,000 cases were reported for 1956 as compared with over 29,000 in 1955).
2. Age distribution studies. (Data from 44 states and the District of Columbia showed a definite shift in the age distribution of paralytic cases in children, with proportionately fewer cases in the 5-9 year old age group upon whom early vaccination programs were concentrated.)
3. Studies in individual states. (A few states have been able to obtain rough measurements of attack rates among vaccinated and unvaccinated children by age groups and their data continue to evidence the vaccine's effectiveness.)
4. The Chicago epidemic. (Cases were concentrated in the age and racial groups and in the sec-

tions of the city where there were the least number of vaccinated persons as opposed to the normal pattern of uniform distribution of cases throughout the city.)

5. Triple vaccination cases. (Up to the present time, three cases of polio deaths among children with three injections have been reported to the Poliomyelitis Surveillance Unit. Two were subsequently revoked, and one remains on the list but is unconfirmed.)

These and other data from the 1956 experience provide valid justification for intensifying vaccination programs. The data also indicate — and the lesson is underscored by the Chicago experience — that in our 1957 vaccination programs we should strive for uniform across-the-board programs that cover all age groups and all income groups.

Alexander D. Langmuir, M.D.
Public Health Service,
Department of Health, Education & Welfare.

Pregnancy and Polio

There appears to be indisputable evidence in extended studies of several hundred cases of poliomyelitis in Los Angeles and Milwaukee that the pregnant woman is more susceptible to poliomyelitis than the non-pregnant woman. These studies were carefully carried out by Horne and Fox respectively.

There are many other reports confirming these findings now appearing in the literature.

Of great importance is the fact that the virus has been recovered both in the placenta and the fetus, and poliomyelitis has been diagnosed in the newborn at the time of delivery.

Obstetricians have accepted these reports and are in favor of the administration of the Salk vaccine to pregnant women. This vaccine when given to the pregnant woman produces active immunity in the mother and passive immunity in the fetus.

Finally it should be advised that pregnant women be given a priority rating for the Salk vaccine.

Aspects of Chest Pathology Affecting Anesthesia (cont'd)

intracardiac lesions have altered radically in nature and scope. The introduction of profound hypothermia and extracorporeal circulations have allowed complete isolation of the heart as a functional organ. This whole subject is in a sufficient state of flux at the moment that the influence of such techniques on anesthesia is difficult to evaluate. It does seem established that little or no anesthesia is required when body temperatures fall below 32° C.

Summary

1. The effects of certain pulmonary and cardiac diseases on the conduct of anesthesia have been discussed.
2. The importance of light anesthesia has been stressed.
3. The necessity of adequate pulmonary ventilation to maintain proper arterial oxygen saturation and carbon dioxide tension has been emphasized.

Studies on the Use of Promazine in Acute and Chronic Nervous and Mental Disturbances

W. E. BURDINE, M.D., T. E. SHIPLEY, M.D., and A. T. PAPAS, Ph.D., Atlanta, Georgia

THE CHEMICAL APPROACH to psychiatric treatment holds considerable promise of improvement in the management of agitated episodes accompanying acute mental disorders, as well as the periods of confusion and abnormal behavior occurring intermittently in the senile and chronically ill.¹ The sedatives in earlier use were never satisfactory because the soporific action of all was attended by undesirable cortical depression. This was an important deterrent, since chemical agents do not alter the underlying pathologic mental processes, and repeated and often prolonged medication is required to control behavior problems. Narcotics and hypnotics are also dangerous from the standpoint of progressive tolerance on the part of the patient, with risk of increase in tension and restlessness or intoxication from overdosage. Dependence on such agents may develop, and with many there is a definite liability to addiction. Alcoholics frequently become habituated to the "after-kick" of barbiturates. The barbiturates should be administered with extreme caution to psychoneurotics, and in the aged should not be used at all.²

Various new compounds with sedative potential have been studied by this group and many others^{1,3-15} with the hope of shortening the hospitalization required for control of acute excitation, and to render more manageable the permanently institutionalized chronic patients. Regrettably, the agents derived from Rauwolfia and certain of those from phenothiazine, although capable of exerting a quieting influence without hypnosis in some patients, have produced untoward reactions ranging from the discomfort of itching rash or gastrointestinal upset to serious and even fatal neurotoxic and hematological disturbances.⁸⁻¹⁵

Our attention was attracted by reports of animal¹⁶ and clinical³⁻⁷ studies of another member of the phenothiazine group. This compound, promazine (Figure 1), is said to exert the "narcobiotic" action of Decourt¹⁷ on the subcortical areas, and clinically it has been shown to control overt motor and verbal hyperactivity.

Promazine possesses the same basic molecular structure as chlorpromazine (Figure 2), but lacks

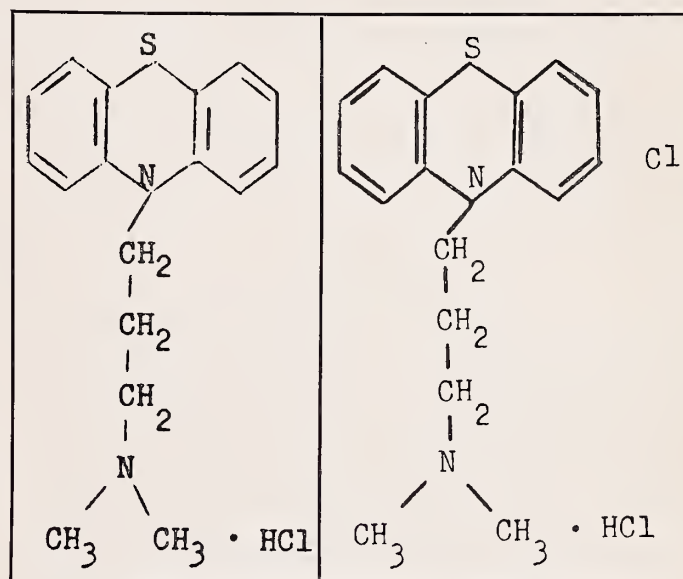


Figure 1
Promazine Hydrochloride

Figure 2
Chlorpromazine Hydrochloride

the chlorine atom. It is believed that omission of the chlorine radical from the formula may be responsible for the absence, in promazine, of the pronounced depressive and other undesirable activities associated with the chlorinated compound, chlorpromazine. Another research group,¹⁸⁻²¹ working in the antibiotic field some years ago, made similar observations during the development of tetracycline from chlortetracycline and oxytetracycline. They found that removal of the chlorine atom from the basic molecule resulted in entirely comparable therapeutic effects, and that the untoward side actions of the earlier compounds were minimized or eliminated.

Method

Thirty-seven patients institutionalized in two private sanitariums were treated with promazine* for control of episodes of severe agitation in acute and chronic nervous and mental disturbances. The ages ranged from 21 to 97 years. Diagnoses included chronic brain syndrome (organic brain disease of all types, including arteriosclerosis and cerebrovascular accidents in senile patients); acute anxiety with agitation and depression; acute alcoholism, with delirium tremens, hallucinations and delusions; drug ad-

* Sparine® Hydrochloride, Promazine Hydrochloride, was supplied by Wyeth Laboratories.

Diagnosis	No. Patients	Individual Dose mg.	Schedule	Route	Results
Chronic brain syndrome	19	Initial - 50 Maint. - 25) 100)	q.i.d. t.i.d. h.s.	I.M. Oral Oral	Quieter, easier to manage; usually responded in first 3 days permitting reduction of dose to maintenance level.
Acute alcoholism	6	Initial - 50 Maint. - 100 to 150	repeated as required q.i.d. every 4 hours	I.V. or I.M. Oral Oral	All discharged in 5 days.
Drug addiction	4	Initial - 50 to 100	q.i.d.	I.M. or Oral	Withdrawal symptoms alleviated. Discharged in about 3 weeks. 3 on maintenance medication.
Acute anxiety	4	50 to 100	every 4 hours or q.i.d.	I.V. I.M. or Oral	Discharged in 9 to 21 days.
Manic-depressive psychosis	3	100 to 200	every 4 hours around the clock	I.V. or I.M.	Rapid control of excitation. Need of ECT reduced by 50%. Less preshock apprehension and post-shock confusion.
Schizophrenia	1	Initial - 25 Maint. - 100	stat q.i.d.	I.M. Oral	Discharged in 3 weeks. Fewer ECT required.
	37				

Table 1
Promazine Treatment of 37 Temporarily or Permanently Institutionalized Psychiatric Patients

diction; manic-depressive psychoses (manic phase); and schizophrenia.

Chlorpromazine has been included in the routine management of such cases since the time the compound was introduced. Thus most of the patients in this series had received chlorpromazine previously. The tranquilizing effect was satisfactory in general, but side effects, particularly a noticeable drop in blood pressure, were seen in a significant number of cases.

Promazine was administered in *dosage* ranging from 50 mg. twice a day to 200 mg. every four hours around the clock, according to the excitation and tension of the patient. The intravenous or intramuscular route was used only during the acute stage. For maintenance therapy after initial control of agitation, the medication was administered orally (Table 1), for periods up to four weeks.

Chronic brain syndrome. All 19 of these permanently hospitalized chronic patients were agitated and noisy, and eight were incontinent. On promazine, the entire group became quieter and easier to manage, generally in about three days. All appeared better oriented and were able to socialize more readily. At present the entire group has been under treatment for about three months, and all are still receiving the medication.

Of the six *alcoholics* included in the study, three were new patients and three had been hospitalized here previously. The highest daily dosage required to control symptoms was 1.2 Gm. a day, with an average daily dose of 600 mg. The maintenance dose was usually 100 mg. four times a day by mouth; for two patients this amount was increased to 150 mg. every four hours. Five demanded supplementary alcohol during the first 24 hours, and the sixth for 72 hours.

One had, in addition, three doses of paraldehyde. Whereas with conventional methods the hospital stay had been 10 days or more, after medication with promazine each was discharged in about five days. All were discharged on out-patient psychotherapy, and the four who have continued to the present have remained sober.

Drug addiction. Three of this group were addicted to *barbiturates*. Two, a 29-year-old male and a 37-year-old female, after first taking barbiturates nightly for sleep, had gradually increased their total daily dosage to six to 15 grains. The third, a 48-year-old female, a drug addict for five years, had been taking 30 to 60 grains a day for several months. The first two were hospitalized about three weeks, and are now on out-patient medication with 400 mg. meproamate** three times a day for maintenance. We have been unable to control the third patient satisfactorily because of the noncooperation of her family. She has never remained in the hospital long enough at any one time for adequate treatment; and is at present at home, taking four to six grains of a barbiturate nightly, against medical advice.

On promazine medication the *morphine* addict, an 86-year-old woman, underwent abrupt withdrawal successfully with very few symptoms. Some faintness occurred on the first day, and occasionally there were leg cramps.

Acute anxiety subsided in three of the four patients in this group in nine to 11 days; only one remained in the hospital the usual three weeks. All became readily amenable to psychotherapy, have adjusted well, and are still under out-patient psychiatric treatment.

** Equanil® Tablets, Meproamate, were supplied by Wyeth Laboratories.

The three patients (two males aged 41 and 48, and one female aged 41) admitted in the manic phase of *manic-depressive psychosis* improved very rapidly under treatment, and in 48 to 72 hours were socializing with the other patients. Electroshock, ordinarily employed for such cases, was required for only one. Although the agitation of this patient was controlled by the medication, four shock treatments were administered to eliminate persistent grandiose delusions. Now on out-patient psychotherapy he is working and doing very well. All of the group are continuing on maintenance medication.

The *schizophrenic*, a 21-year-old female showing incongruity of affect, hallucinations, and pronounced psychomotor retardation, received six electroshock treatments concurrently with the medication, with satisfactory improvement. She was discharged in three weeks, whereas usually six weeks' hospital treatment and at least 10 electroshocks are generally required.

Discussion

Our results with promazine were uniformly good; the therapeutic effects were equal in all respects to those previously obtained with chlorpromazine, although it was necessary to use slightly higher dosage. The compound has a definite place in the management of central nervous system excitation, especially in the chronic brain syndrome.

The need of electroshock therapy was reduced by about 50 per cent, and there was usually less pre-shock apprehension and postshock confusion.

In general there were no significant changes in blood pressure or pulse during medication, other than the gradual response normally to be expected with subsidence of excitement and tension. No jaundice, agranulocytosis, disturbances of the basal ganglia, or other manifestations of toxicity developed. With chlorpromazine, however, a drop in blood pressure occurred frequently. Brief dizziness was reported by five patients in this series in the first few days of medication, but it is questionable that the drug was responsible. We are inclined to feel that the dizziness was part of the severe anxiety reactions from which they were suffering, since the dosage was continued in the same amount, and the dizziness did not recur as their condition responded to treatment. Salivation was reduced in eight patients during the first three to five days, then in all but one returned to normal. This patient continued to experience mouth dryness in somewhat less degree after the fifth day.

Summary

Thirty-seven psychiatric patients, institutionalized for short term treatment of acute episodes or permanently for care of chronic nervous and mental dis-

turbances, received promazine as part of the therapeutic regimen.

The patients in the series ranged in age from 21 to 97 years. Most had received chlorpromazine in previous admissions or courses of treatment.

The clinical response to promazine was uniformly good, with therapeutic effects equal in all respects to those obtained with chlorpromazine. Unlike the experience with chlorpromazine, there was no significant circulatory change except the gradual lowering of blood pressure and slowing of the pulse rate normally to be expected from subsidence of excitement and tension. No manifestations of acute or chronic toxicity developed.

Promazine has a definite place in management of central nervous system excitation, especially in the chronic brain syndrome.

849 Peachtree Street, N.E.

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Evaluation of Metreton Suspension in Ophthalmology

J. MASON BAIRD, M.D., and HARRY D. ARNOLD, JR., M.D., Atlanta, Georgia

IN THE SEARCH FOR improved steroid compounds, a new metisteroid-antihistamine preparation called Metreton Ophthalmic Suspension is clinically evaluated in this paper. Many reports have appeared in the literature concerning the effectiveness of prednisolone in the treatment of ophthalmic diseases.¹⁻⁵ Its clinical usefulness is now firmly established and widely recognized. Among the actions resulting from the use of 11-oxycorticoids, ophthalmologists note in particular the marked anti-inflammatory and antiphlogistic action along with considerable depression of all elements of granulation tissue (less scarring) and substantial protection afforded single cells from degeneration.⁶ In Metreton Suspension, prednisolone is combined with new salt of Chlor-Trimeton (Chlor-Trimeton Gluconate) as 0.3% Chlor-Trimeton Gluconate and 0.2% prednisolone acetate. Chlor-Trimeton Maleate is a well-known antihistamine and acts, as do other antihistamines, according to the Feinberg Theory in replacing histamine due to its structural similarity at the site of action in a receptive cell. Antihistamines reduce capillary permeability, and hence less edema and swelling occur following their use. Thus it seems logical that an antihistamine solution would be effective when applied locally as well as when taken internally in reducing or eliminating the histamine type of response.

Metreton seems to be well tolerated by ocular tissues; we have not a single case that was adversely affected from this suspension. This is confirmed by a paper to be published by Abrahamson and Abrahamson⁷ who report no untoward effects or toxicities in any of 700 cases treated topically with Metreton Suspension. Several patients did complain of grittiness from the prednisolone suspension. However, in adding an antihistamine solution to the steroid suspension, the required therapeutic concentration of the steroid is reduced as is the amount of objectionable particulate matter placed in the eye.⁸⁻⁹ We are currently studying the newer soluble steroid compounds and in due time will report comparative observations and results with these newer experimental ocular solutions and Metreton Suspension.

Metreton was supplied by Harry V. Pifer, M.D., Clinical Research Division, Schering Corporation, Bloomfield, N. J.
From Department of Ophthalmology, Emory University School of Medicine, Atlanta, Ga.

The clinical evaluation made in this report is based on both subjective and objective response in 63 patients seen in private practice with adequate follow-up visits. Classification of the amount of improvement is always difficult, so to make it as simple and accurate as possible, the response was graded as Much Improved, Improved and Unimproved. As mentioned earlier, none of the cases were, in our opinion, made worse.

The most significant response occurred in allergic conjunctivitis where out of 19 patients, 17 were Much Improved and two Improved. In most of them there was a dramatic relief of burning and itching a few minutes after application of the drops. In the vast majority there was definite improvement both subjectively and objectively in 24 to 48 hours, and lacrimation, often a troublesome symptom in these patients, was greatly lessened. Although there is a considerable amount of overlapping in the classification of allergic conjunctivitis as opposed to chronic bacterial conjunctivitis, our differentiation was made as follows.

Classified as allergic were those with some or all of the following features:

1. Pale edematous conjunctiva.
2. Burning and itching most prominent symptoms.
3. Mucopurulent discharge with little or no lid margin involvement.
4. Familial history of allergy.
5. Seasonal incidence.
6. Predominance of eosinophils on smear.
7. Presence of other systemic or local allergies.

Since the allergy is not cured, frequency and duration of treatment should be based on maintaining the patient free of symptoms. This may vary considerably from month to month and year to year. Desensitization to pollens and dust may be helpful in some of these cases, but this is a prolonged and expensive treatment.

One case of allergic conjunctivitis of unusual severity merits further consideration. A five year old boy had, by history, continuously red eyes for some two years with itching, tearing, photophobia, lid edema, and squinting. Six months prior to being seen in our office two chalazions had been curretted. Except for temporary improvement with an ointment

containing hydrocortisone and chloromycetin, treatment with several types of eye drops and ointments had failed. When we first saw this boy, he had a severe bilateral punctate keratitis. Culture showed hemolytic staphylococcus (coagulase negative) most sensitive to erythromycin. On erythromycin solution (five mg. per cc.) every hour and erythromycin ointment at bedtime, the mattering which had been present in the mornings cleared, but infection and keratitis remained unchanged after one week. The erythromycin was reduced to four times a day and supplemented with Metreton Suspension every two hours. There was dramatic improvement, with the eyes almost white in 48 hours, and after one week there was no corneal staining. The frequency of Metreton administration was then gradually reduced and after one month stopped altogether. Six months later the patient was entirely free of infection and asymptomatic. Some seasonal recurrence of allergy, however, is to be expected.

There were four cases of vernal conjunctivitis probably of allergic etiology, and all were classified as Much Improved after treatment with Metreton Suspension. In one case it was felt advisable to use systemic Metreton to supplement the local treatment.

Of the eight cases of superficial punctate keratitis, three were Much Improved, and five showed some improvement. Most of these were treated with an antibiotic solution in addition to the Metreton. The failure to get results comparable to allergic conjunctivitis can be explained by the multiple etiological factors in superficial punctate keratitis. These include, allergy, bacterial infection (especially staphylococcus), keratitis sicca, drug sensitivity, exposure to dust and fumes, and even systemic diseases. Although epidemic keratoconjunctivitis can cause a superficial punctate keratitis, no case recognized as such was included in this group. Of course, a thorough search should be made for the etiology in cases of superficial punctate keratitis and treatment directed toward eliminating the cause.

Twenty-two patients were listed as having chronic conjunctivitis and of these 10 showed Much Improvement, 10 were Improved, and two showed No Improvement. In chronic conjunctivitis there is frequently both an element of infection and allergy, with the allergy often being due to the infecting organism. Many of these infections are long-standing and difficult to eliminate. Smears, cultures, and sensitivity tests are indicated to find the antibiotic of choice. Desensitization to staphylococcus toxin is sometimes helpful in the more resistant cases due to a staphylococcus infection. The indication for Metreton Suspension in cases of chronic conjunctivitis is principally an effort to make the patient more comfortable during the often prolonged period of treatment. The

same applies to chronic meibomianitis which is very difficult to treat successfully and often requires frequent expression of the meibomian glands. Systemic administration of antibiotics may help get a sufficient concentration to these deeply situated glands. Of six cases of chronic meibomianitis, two showed Much Improvement using Metreton to supplement the above treatment, and four were Improved to some degree subjectively.

Metreton Suspension was used on two cases of epidemic keratoconjunctivitis. Both developed corneal infiltrates, and one ran a protracted course of four weeks with severe inflammation and edema. It was our impression that neither showed any improvement with Metreton.

In addition to the above, there was one case of pingueculitis and one of episcleritis which were thought to respond well to Metreton.

Since the steroids have been shown to decrease the normal defense barriers to infection and may modify the formation of antibodies, steroid compounds should be used in an acute infection with extreme caution, if at all. We have seen five patients with corneal ulcers due to bacterial infection which we feel were definitely made worse by topical steroid preparations even though in most of them an antibiotic was combined with the steroid. The use of steroids are contraindicated in active dendritic infections, in the presence of hyphemia and after extra capsular cataract extractions with retained cortex.

Summary

Sixty-three patients treated with Metreton Suspension with follow-up visits are evaluated as to their objective and subjective response. The response was considered excellent in allergic conjunctivitis and vernal conjunctivitis.

Many patients who had tried other steroid preparations considered Metreton superior to any treatment they had received. Metreton Suspension is also useful in relieving troublesome symptoms in many cases of chronic conjunctivitis and meibomianitis where it can be used in conjunction with the antibiotic of choice. The same contraindications seem to be applicable as with other steroid preparations. No allergic or other untoward reactions were noted in any of the 63 patients.

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What Does Your Patient Read?

HAVE YOU TAKEN A MOMENT lately to check the reading material in your waiting room? If so, does it include issues of *Today's Health*, published by the AMA — the magazine which never goes out of date, and which is one of the most popular on the reading table.

Why Have Today's Health? — If you have had occasion lately to examine the so-called “popular health magazines” which are offered on the newsstands to the general public, you will say, “Thank goodness for *Today's Health* magazine as an antidote to that type of misleading, and so often inaccurate, health information.”

Today's Health is published by the American Medical Association for the express purpose of putting authentic health information into the hands of America's reading public. Its colorful covers are always eye catching, the format is modern and appealing, and its articles are written by competent authorities in a very readable and understandable way. There is no better investment in the health education of your patients than to make sure copies of *Today's Health* are available to them in your waiting room.

Is the Patient Interested in Health Subjects? — Yes, very much so, as witnessed by the overwhelming popularity of syndicated columnists such as Dr. Alvarez, the high ratings of such television programs as “Medical Horizons”, and even the very popular comic-strip character, Rex Morgan, M.D. Also, the fact that the patient is in your waiting room means that he has a very subjective interest in his own health at the moment and for that reason is most susceptible to magazines with subjects dealing with health. You should make sure that the material he reads is authentic and accurate.

Who Sells Today's Health? — The promotion of good health education in the community is one of the main projects of the Woman's Auxiliary to the American Medical Association. For that reason, every local and state auxiliary has a *Today's Health* Chairman as one of its vice-presidents. It is her job, and her committee's job to promote subscription drives and to follow up the renewals. So when your local auxiliary gets in touch with you to take out a



Is this a typical scene in your waiting room?

subscription or renew your subscription, give it your wholehearted support, the auxiliary is doing a big job in the interest of community health.

Because of the fine job the Woman's Auxiliary to the Medical Association of Georgia has done (over 100% of the 1956 quota), the Circulation Department of *Today's Health* has given an added boost by sending out over 2,000 free eight-month subscriptions to Georgia doctors who were not receiving the magazine at their office addresses. These physicians will be contacted at the end of eight months for a renewal of that subscription.

How Much Does It Cost? — Physicians, dentists, auxiliary members, residents, interns, and medical students are entitled to buy a subscription at the special rate of \$1.50 per year. It is sold at the regular price of \$3.00 per year to all other individuals, schools, libraries, etc.

Next time a copy of *Today's Health* comes your way, really take a good look at it and see if you aren't pleased with the kind of publication the American Medical Association puts out for the American reading public. Do your AMA a favor and support it with your subscription. Do your patients a favor and give them good reading material . . . and most of all, do yourself a favor . . . by subscribing to *Today's Health*.

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Posture and Pain

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THE GREAT VARIETY OF major medical and surgical crises are described in many volumes, and the meetings of learned physicians are given over to discussions of pathological conditions; little time or space, however, is devoted to a condition which is so common as to affect each person at some time during each day. Effects of poor posture may range from a transitory discomfort of only a few moments duration to a constant nagging pain which lessens efficiency without stopping production, or to an acute illness which falls within the category of seriously disabling disease. It is not within the scope of this paper to discuss organic pathology, but rather to point out some of the faulty habits of body mechanics which render you and me, our families and our patients, people with varying degrees of disability.

In good posture, body segments are aligned for proper distribution of stress upon bony structure, muscles are at a length which allows for the most efficient contraction and minimal strain, and joint components are under evenly distributed tension. From the posterior aspect, a plumb line passes from the center of the occiput, through the length of the spine, to a point midway between the heels. From the lateral aspect, the plumb line passes from the lobe of the ear midway through the tip of the tip of the shoulder, midway through the trunk, through the greater trochanter, slightly anterior to the midline of the knee, to a point slightly anterior to the lateral malleolus.

Provided there are no abnormalities of bony structures or shortening of ligamentous tissues, alignment of body segments is dependent wholly upon muscle tone and strength with interplay of various groups in the activities of sitting, standing, and moving about.

Posture originates at the feet; unless the foundation is firm, the superstructure can not be stable. The keystone of posture is the lumbosacral junction which is maintained by upward pull of the abdominals and downward pull of the gluteals. The other end of the span is the scapula adductors which lock the shoulder girdle into a relaxed position. These three factors—stability of the feet, of the lumbosacral joint, and of the scapulae are the essentials of comfortable skeletal alignment. Disturbance of any

one produces secondary tension which reaches from the occiput to the toes.

There are as many varieties of deviation from good posture as there are faulty postural habits, but five main categories may be distinguished. In that characterized by kyphosis, lumbar tissues and hip flexors are tight and strong, while scapula adductors, abdominals, and hip extensors are weak and stretched. Patients in this group commonly complain of pain originating at the base of the neck, radiating out into the shoulders and to the interscapular area. Severe pain and limitation of the shoulder, or a shoulder-hand syndrome may be a complication attributable directly to this postural defect, and treatment must include both cause and effect. Low back pain of varying degrees of severity often radiating down the posterior aspect of the leg is a common presenting symptom, and the examiner may experience difficulty in ruling out the diagnosis of herniated intervertebral disc. These individuals have very unstable backs and are subject to acute strains with minimal forces.

In the flat back posture, there is a posterior tilt of the pelvis with tightness of hamstrings and weakness of hip and back extensor muscles. These patients commonly complain of a "tired back", although occasionally there may be actual pain about the hips due to constant strain of its anterior structures, or about the knees which may be in flexion because of hamstring tightness.

The stoop-shouldered adolescent is laying the foundation for the adult complaints of neck pain and stiffness, headache and chronic fatigue. Scapula adductors are weakened and stretched, and pectorals are tight. In the adult, fixed deformities of the cervical spine may occur, giving rise to cervical radiculitis and symptoms which resemble those produced by a cervical disc.

Misdirected attempts at standing correctly may result in the so-called "military posture", which is productive of generalized muscle tension, fatigue, and discomfort. Tightness is found in the lumbar and lower dorsal areas, and in the superior aspect of the shoulder girdle.

Probably the most common posture fault is that due to obesity in which no effort is made to support the weight of pendulous breasts and abdomen. Low back pain is nearly always found in fat people,

Presented at the Annual Session of the Medical Association of Georgia, May 13-16, 1956, Atlanta, Ga.

associated with posterior neck pain from constant compensatory extension. The weight of the sagging abdomen may be so great as to cause pain at the costal margin from chronic strain of abdominal muscles at their insertion. Here is found tightness of hip flexors, neck extensors, and lumbar tissues, and weakness of abdominals and hip extensors.

It has been pointed out that faulty use of normal structures can result in pain in the feet, knees, hips, back, neck, shoulders, hands, and head. Among the more common causes are, first, inherent tissue structure defect which allows rapid development of fibrosis or hypotonia. This may be called the bonfire which is laid and waiting for the match of any of the following causes: emotional tension, attitudes of depression, aggression, insecurity, and guilt reflected in physical attitudes; occupation, obesity, fatigue, standing or sitting habits, poorly fitted shoes, or shoes without good support, constant use of high heels, a sagging mattress, or a chair which will not allow good posture.

Dynamic posture defects may be seen in early childhood in habits of carrying books, reading, and sitting at improper desks. If these habits are perpetuated, a static posture defect in the adult may be the end result.

Because poor dynamic posture frequently causes sudden severe back pain, maintenance of back health should be as much a part of daily routine as is cleansing and grooming. The basic principles are stability of the feet, the lumbo-sacral junction, and the scapulae, with relaxation of the shoulders. Sitting, writing, reading, reaching, stooping, and lifting can be performed efficiently and safely by use of proper body mechanics, or they can result in disability if strain is misdirected.

Prevention or correction of poor posture requires 24 hour-a-day observance of the basic rules of good posture, both static and dynamic, plus a few minutes each day spent in correction of whatever defects exist.

Shoes should be long enough that the widest part of the foot falls at the widest part of the shoe, and

the toes allowed sufficient room for spreading. Foot stability can be obtained only with a firm sole and support across the instep, with metatarsal pads, bars and built-in arches inserted as necessary. Heels for routine wear should be low or medium, but any height is allowable for dress occasions. The importance of adequate length of hose is often overlooked as a cause of foot strain. A firm mattress with a bed board and a car seat are a part of every posture patient's daily living, and are equal in importance with good seating facilities. Ideal chair design provides for an angle of 110° between the seat and the back, with flat support at shoulder level and with maintenance of the normal lumbar curve by a moderate amount of pressure. Posture consciousness should be practiced until it become habitual to stand, sit, and move with abdominal and gluteal muscles contracted and shoulders relaxed.

Stretching of the hamstrings and low back is best accomplished in the long sitting position; in normal range, the finger tips reach the toes. Strengthening of abdominal muscles, together with back stretching, is accomplished with William's exercises and strengthening of scapula adductors with activities directed toward this group.

Corsets or braces may be necessary in those instances in which the defect is severe, but the application of such a supportive device can be for temporary use only if a true effort is made to correct posture and avoid pain.

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Doctors Plan Own Periodic Checkups

OMAHA, Neb.—Members of the Omaha-Douglas County Medical Society are doing what doctors all over the country have been talking about doing for years but haven't yet done. They've organized a program of periodic physical examinations for physicians.

Obviously, the program had to be voluntary. So the society polled its 400-doctor membership. Half the members responded that they would not only

co-operate but would encourage their colleagues to do likewise. All but 12 of the 200 replying named the physician of their own choice. The 50 or so examining physicians thus named were given lists of their prospective "patients" and made appointments for them. Some of them — mostly internists — had to schedule as many as 12 of their colleagues.

Fees? Absolutely not. So, as one member suggested, "it may be pretty rough on the internists."



Strike Your Blow

THIS MONTH IN GEORGIA a crusade is being launched. This crusade marks the fruition of a long frustrated dream. We, as guardians of Georgia's health, are called upon to energize and promote as a public service, a statewide campaign against a common enemy that has cost many lives and caused much suffering. That enemy is poliomyelitis.

On April 12, 1955, the announcement was made that a polio vaccine developed by Dr. Jonas E. Salk, was safe and effective. Nearly two years have elapsed since that announcement, and during that period some 45 million American children and expectant mothers have received at least one inoculation.

Because of shortness of supply at that time, efforts were concentrated on that segment of our population which was most susceptible.

Experience indicates that the older the person is when stricken by polio, the more devastating the effects of the disease. Seventy per cent of all respiratory cases in this country are 20 years of age or older.

It has been well demonstrated that up to 90 per cent of those individuals receiving the full course of three injections of vaccine will be protected against polio.

So far only one out of every six adults between 20 and 35 years of age has even started on his inoculation program. This means that less than half of the population who can benefit from the protection of the Salk vaccine have taken advantage of its availability. Those who fail to receive their initial inoculation this year will once again be vulnerable to the disease when the polio season begins.

Now the campaign to prevent polio has moved into a new phase; that of getting the entire public inoculated, particularly those up to age 40. Yet, in spite of a concerted effort on the part of many different groups and organizations to encourage all to be vaccinated, we have fallen far short of the goal.

The national supply of Salk vaccine is now sufficient to provide the full three injection series for all men, women and children under age 40.

The real enemy now is not the disease itself, but public apathy. The prevention of poliomyelitis is now as much an educational problem as it once was a medical problem.

The leadership of the medical profession in the conduct of an educational campaign and in the

administration of the Salk vaccine is now the key to the control of paralytic poliomyelitis. The specific steps of cooperation cannot be prescribed on a national or state basis but must be handled at the local level.

If a sound program is planned at the local level, we will have the public's support in accepting this reward from the laboratories of American medicine. The battle against polio, partly won, now needs the understanding, the endorsement and wholehearted support of all physicians on the home front. We must think above all in terms of public service; since medicine is a public service profession, we should and must do everything possible to inoculate every eligible person regardless of ability to pay. Let us all join hands and "strike our blow at polio"—now.

You Should Attend the Annual Session—Why?

THE 1957 ANNUAL SESSION of the Medical Association of Georgia will convene on April 28-May 1, within the next few days, at the Hotel DeSoto, Savannah, Georgia. This session will mark the high-point of medical meetings held in Georgia this year, with 15 specialty societies participating. Some 20 nationally known out-of-state physicians and surgeons are scheduled to present papers covering the entire field of medicine. From over the state, 50 of our own doctors will also present papers of outstanding interest.

In this era of social and economic change, the business of the component county medical societies takes on greater importance, especially with the increasing demands being made upon the doctors engaged in the practice of medicine. Two sessions of the House of Delegates will be convened to consider these important matters.

The meeting affords an opportunity for old friends and their wives to renew acquaintances and "swap tales of yesteryear." The doctors of Savannah and their good ladies, with customary Georgia Medical Society hospitality, have arranged a multitude of social festivities for visiting doctors and their wives.

J. G. McDaniel, M.D., Chairman
Council Committee on Annual Session

Urology and the Aged

THE UROLOGIC SURGEON is no longer faced with the simple problem of whether to remove the elderly male's prostate or return the patient to his home with



EDITORIALS

an indwelling catheter. The question is far more complex. The answer depends not only on the competence of the urologist, but upon the results of a battery of examinations, tests, and consultations. After these seemingly unrelated data are compiled and their results competently interpreted, their application to the elderly urologic patient often permits surgical correction of an otherwise intolerable situation.

While benign prostatic hypertrophy and prostatic carcinoma are the companions of the older American male population, they are not necessarily the only urologic abnormalities with which this increasingly large population is confronted. Kidney stones, of which ureterolithiasis is a frequent associate; hypernephroma; carcinoma of the bladder; traumatic disruption of the various components of the genitourinary tract, and a few infrequently encountered abnormalities constitute the major urologic pathological abnormalities to which the elderly male and female are heirs.

The joint efforts of the anesthesiologist, internist, and urologic surgeon have resulted in the reduction of mortality rates in prostatic surgery to less than one per cent. Age is no barrier to prostatic surgery. The result of such operative intervention is in direct proportion to the competence of the three men responsible for the patient. Age of the patient, recent cardiac embarrassment and size of prostate are not barriers in the way of prostatic surgery. The management of incipient as well as advanced cardiac failure is more satisfactory in the patient whose urinary tract is not compromised by an obstruction at the vesical neck. Increased hours of uninterrupted sleep, reduction of diurnal tension, and a sense of well-being are the usual rewards for a week in the hospital and 90 minutes in the operating room.

Those urologists who undertake radical prostatectomy for operable prostatic carcinoma arbitrarily draw the line for this two-hour surgical experience at age 70 years. However, the chronological age often belies the physical age, and there are males who at age 70 experience a unique sense of active

libido, sexual potency, and aggressiveness. Therefore the age limit for radical excision for operable prostatic cancer is a flexible factor and must be determined on the basis of individual evaluation. Again the competence of the anesthesiologist, internist, and urologist will determine the mortality rates in either radical perineal or retropubic prostatectomy. In the best hands, the rate is less than that for simple prostatectomy in the same hands. But there are those elderly individuals on whom surgical intervention for removal of vesical neck obstruction would leave incontinent. Cerebrovascular accidents are notorious for rendering the patient mentally incapacitated and incontinent of urine and feces. The judicious use of the indwelling catheter and daily enemata will gain the praise of the nursing staff, patient, and family. Where there is the possibility of improving the urological picture, prostatic surgical intervention can be safely performed at a propitious moment.

The aged person is not free from the ancient affliction—urolithiasis. On the contrary, calculi may be dormant for many years and manifest themselves late in life by the simple sign of recurrent or persistent urinary tract infection. The preparation of these patients requires the same intelligent preoperative approach as preparation of the prostatic candidate.

While it is foolhardy indeed to submit an elderly patient to a seemingly heroic surgical performance, there are occasions when the bull must be taken by the horns and a gallant attack made. Elsewhere the initial sin of urinary cancer has been referred to as the "blood bath" sign. Often bleeding due to cancer of the kidney, ureter, or bladder is stubbornly active and persistent. Extirpation of all the organ (kidney and/or ureter) or part (bladder) is necessary to interrupt the blood loss when other measures such as radiation therapy have failed. Every urologist worth his salt has been faced with the octogenarian, yes the nonagenarian whose only hope for survival was a nephrectomy and/or a ureterectomy and possibly bladder surgery for incurable cancer. Surgical intervention with proper preoperative evaluation and preparation frequently permits several additional trouble-free years of life with friends and family.

Postgraduate Courses in Georgia

Fractures in General Practice
Medical College of Georgia
June 13-15, 1957

Common Diseases of the Blood
Emory University School of Medicine
May 15-16, 1957

The Diagnosis of Dissecting Aneurysm

T. STERLING CLAIBORNE, M.D., Atlanta, Georgia

A GOOD DEAL OF ATTENTION has been called to dissecting aneurysm of the aorta to encourage its more frequent diagnosis *anti-mortem*. Such diagnosis may be more important in the future with the development of cardiovascular surgery and its aid in certain patients with aortic dissection.

This diagnosis will frequently be missed unless one keeps it in mind when seeing any patient who shows a rather sudden involvement of any part of the vascular system. This involvement may affect almost any part of the body. It is not sufficient to look for the patient with a tearing and terrible pain in the chest, with radiation or spread into the back and then downward. Too much has been said of this type of pain; many are the patients who do not have such pain with the splitting of the aortic wall. In these cases the clues to the diagnosis result from the splitting of the media of the vessels leaving the aorta, or the blockage at their origin. Only recently two patients were seen who presented as mild dorsal back strain which required no narcotic. One was diagnosed by the temporary blocking of an arm and leg vessel and the other by the shadow on x-ray of the change in aortic width. It is wise to realize that this is a changing disease or condition; the dissection progresses in devious ways, and the signs, accordingly, do likewise. Numerous patients with dissection occurring about the carotid arteries have presented as "strokes" because of the expected block in cerebral flow.

A changing chest pain and changing temperature, pulse, and blood pressure in an extremity mean dissecting aneurysm of the aorta. An acute abdomen may not be due to mesenteric thrombosis but to dissecting aneurysm blocking this artery. An acute abdomen with expanding retroperitoneal mass and rapid anemia may mean a rupture of tubal pregnancy in a young woman and may mean a retroperitoneal rupture of a dissecting aneurysm in a

hypertensive woman of 60 years. Chest pain or back pain, and acute flank pain with hematuria, is seen when a dissecting aneurysm causes renal infarction on one side; and a bilateral block leads to rapid anuria and uremia. Before embolectomy is advised for acute occlusion of a femoral artery, one should consider that the block may be due to dissecting aneurysm, even though there has been no "tearing" pain.

The course of dissecting aneurysm often is rapidly fatal as a result of rupture of the dissecting stream further through the adventitia and into the chest cavity or retroperitoneal space, or more slowly by blocking the flow of blood to the brain, kidneys, or intestinal tract. Or the patient may live and survive a number of years; in this situation the channel usually opens back into the aorta at a lower level and a double-barrelled aorta may be formed, or more rarely the dissected channel may be obliterated by clot and fibrosis. The patient who lives shows evidence of vascular damage of nonfatal degree, low-grade fever, mild leucocytosis, sedimentation rate elevation, and blood pressure drop, all of which vary with the degree of damage.

In an attempt to clinch the diagnosis of dissecting aneurysm early in its course, a close hour-to-hour and day-to-day following of the blood pressure in the extremities and carotid artery palpation are essential. Fluoroscopic or x-ray observations to check the changing aortic shadows are in order. And laminograms may show the ordinary aortic arch calcified plaque to be deep in the enlarged shadow. If one desires to view the path of dissection, contrast media may be used by angiocardiology or retrograde by brachial artery injection with catheter. But again in the diagnosis of dissecting aneurysm of the aorta, a realization of the possibility is of prime importance and then a careful watch for a changing status in any of the arteries of the body must be maintained.

Prepared at the request of the Committee on Professional Education of the
Georgia Heart Association.

abstracts by georgia authors



Findley, Thomas, Medical College of Georgia, Augusta, Ga., "Clinical Syndromes Produced by Isolated Dysfunctions of the Renal Tubule," *Arch. Int. Med.* 99:172-175 (Feb.) 1957.

This is a brief and superficial review of the more important clinical disturbances which result from failure of the nephron to perform specific tasks. Most of them probably represent genetic disturbance in enzyme mechanisms. The clinical syndromes briefly referred to are nephrogenic diabetes insipidus, renal glycosuria, idiopathic hypoproteinemia, primary aminoaciduria, idiopathic hypercalciuria, renal hypokalemia, chloride acidosis, pseudohypoparathyroidism, vitamin D-resistant rickets, the Fanconi syndrome, and essential hypertension.

Sikes, Z. S., V. A. Hospital, Dublin, Ga. "Korsakoff and Wernicke Syndromes: History and Treatment," *J. Nerv. and Ment. Dis.* 5:448-451 (May) 1956.

A review of the literature is presented, including excerpts of original papers by Korsakoff and Wernicke. Some of the earlier theories of etiology are described, leading to present concepts and reasoning that complicated thiamin deficiency is the cause of Wernicke's syndrome. It is pointed out that Korsakoff and Wernicke syndromes are by no means limited to alcoholics. The author feels that the alcoholic psychoses, Wernicke and Korsakoff syndromes appear clinically to be degrees of the same underlying process although emotional conflicts probably play a part in the total picture of Korsakoff's syndrome. A useful treatment program of therapy of acute cases is described. Rather large dosage of parenteral thiamin is recommended with hypertonic glucose, together with other measures to prevent complications. Use of Chlorpromazine is encouraged over sedative drugs because it does not add drug confusion to an already organically confused patient and the margin of safety is great.

Johnwick, Edgar B., Public Health Service, Atlanta, Ga., "Recent Developments in Public Health Training for Civil Defense," *South. M. J.* 50:113-116 (Jan.) 1957.

The delegation of authority from the Federal Civil Defense Administration to the Public Health Service with reference to public health training, envisions a national program of providing technical assistance to the states in maintaining public health activities under emergency civil defense conditions. This assistance will be provided in the form of general and topical courses in the states, and advanced specialized courses at Public Health Service installations.

Knowlton, G. Clinton, Ph.D., and Robert L. Bennett, Warm Springs, Ga., "Overwork," *Arch. Phys. Med.* 38:18-20 (Jan.) 1957.

From a random survey of patient histories and from observations of the effects of certain prescribed activities in selected individuals, it is concluded that there is a definite hazard to skeletal muscle from overwork. Overwork is evidenced by a long-lasting decrement in muscle performance following upon a series of exercise bouts. While poliomyelitis injured muscle seems particularly susceptible to overwork, it was also noted that normal muscle can be overworked in voluntary activity. The critical situation leading to overwork seems to be when the motivation for performance is so great that subjective fatigue does not serve to terminate the exercise. Thus, in such individuals, objective signs of incoordination and strength decrement must be used to prescribe limitations of activity.

Claiborne, T. Sterling, and Wm. A. Hopkins, St. Joseph's Infirmary, Atlanta, Ga., "Aorta Pulmonary Artery Communication Through the Lungs," *Circulation* 14:1090-1092 (Dec.) 1956.

A considerable number of cases of arteriovenous communications in the lungs have been reported in recent years with the blood flow being from the pulmonary artery to pulmonary veins. In the patient the symptoms are usually of pulmonary type and may include cyanosis and certain to and fro murmurs. But when vessels directly from the aorta flow through an aneurysmal mass into the pulmonary artery the physiology and thus the symptoms of the condition are different. Then they are the symptoms of any high pressure, low pressure shunt. These cases have an increase in left ventricular work.

A report of observations on a 14-year-old girl with a communication between the aorta and pulmonary artery is given. Cardiac catheterization revealed a high oxygen content in the pulmonary artery particularly in the right branch. Physical examination and angiocardiology demonstrated the lesion to be present in the right lower lobe of the lungs and cure was obtained by surgical removal of the right lower lobe.

Greenblatt, Robert B.; Efrain Vazquez; and Irwin C. McLendon; Medical College of Georgia, Augusta, Ga., "Endocrinopathies and Infertility," *Fertility and Sterility* 7:498-507 (Nov.-Dec.) 1956.

The thirty-sixth case of pregnancy occurring in acromegaly is reported. The patient had had symptoms for about five years when she was first seen for this study. She had already developed amenorrhea and some of her features were suggestive of acromegaly.

Roentgen studies, hormonal assays, and chemical studies verified the diagnosis. Steroid hormone therapy, consisting of estrogens and progesterone given orally and by pellet implantation, was the only form of medication employed, irradiation to the pituitary being purposely avoided. Two years and four months after institution of treatment the patient became pregnant for the first time. After an uneventful delivery of a normal child she became pregnant again 10 months later and again carried successfully to term. At the present time, 20 months after the birth of the second child, studies suggest that the acromegalic process is quiescent.

Blackford, L. Minor, 104 Ponce de Leon Ave., Atlanta, Ga., "The Heart and Electrocardiogram of an Alligator," *Circulation* 14:1114-1116 (Dec.) 1956.

Spitzer argued that the cause of congenital heart disease is "an arrest of development at a lower phylogenetic level, related to but not identical with that in reptiles, and the coordination of the features at this stage with those already developed in the mammalian stage." The heart of the crocodile with an aorta arising from each ventricle as well as a pulmonary trunk from the right ventricle particularly impressed him. That anomaly in which the interventricular septum is incomplete and both ventricles send blood into the aorta he explained as "a fusion of both aortas extending from the proximal bulbus to the ventricle."

Accepting this theory, the author has suggested "biventricular aorta" as a term embryologically and anatomically correct, as well as readily understandable, and one that would facilitate the elimination of certain eponyms.

A diagrammatic sketch of the heart of an alligator and an electrocardiogram are presented.

Jungck, Edwin C.; Agatha Moody Thrash; A. P. Ohlmacher; Arthur M. Knight, Jr.; and Lucian Y. Dyrenforth, Dept. of Endocrinology, Medical College of Georgia, Augusta, Ga., "Sexual Precocity Due to Interstitial-cell Tumor of the Testis," *Clin. Endocrinol.* 17:291-295 (Feb.) 1957.

These two cases of precocious puberty due to interstitial cell tumors of the testicle bring the total number of such cases in the world literature to 20, illustrating the rarity of the condition. The diagnosis rests in the concomitant findings of an enlarged testicle and sexual precocity. Along with the sexual disturbance, there is an elevation of the urinary 17-ketosteroids, resulting in advanced bone and muscular growth, advanced bone age, and eventual adult dwarfism. The treatment consists of removal of the involved testicle.



Clinics Owned by Doctors

HAL M. DAVISON, M.D., Atlanta, Georgia

THE TERM "CLINIC" refers to a number of doctors, organized to practice medicine together and presumably in a legal and ethical manner. The term "clinic", however, assumes to the layman a dignity and a meaning not borne out by existing circumstances in many so-called clinics. In other words the term "clinic" may be used as an advertisement in some cases when it is not justified. Up until a short time ago there have been clinics in the United States owned by one doctor with other doctors working for the clinic on a salary. Most of these clinics have disappeared due to the fact that the doctors owning them originally have died and the clinic has been changed to a non-profit organization called an association, partnership, group practice, or a foundation.

In one northern city there was a clinic which opened small private branches in surrounding towns, and when patients who needed hospitalization or surgery came to these branches, they were sent to the parent clinic. In other words, the smaller offices were used as feeders for their larger one. The county society censured these doctors. The state society and the Council of the A.M.A. upheld the findings of the county and forced them to make a change.

In Cleveland, Ohio, the Academy of Medicine sued the Hopkins Clinic which was practicing medicine as a corporation and, in the opinion of the members of the Academy, did not meet the standard of practice which should be demanded by the medical profession as a whole. It is interesting to note here that the Cleveland hospitals came to the rescue of this clinic. The court ruled that the clinic was engaging in the corporate practice of medicine, and the case has been appealed to the Supreme Court.

In Chicago there was trouble with one or two men practicing medicine together and advertising themselves by displaying signs as a clinic where no such organization existed. A sub-committee was

appointed to review and report on what these doctors were doing and what should be done about it. The definition of a clinic accepted by the Chicago Medical Society is "a clinic or medical group practice is the formal association with a common organization of a number of licensed physicians providing services in one or more fields of medicine as specialists, with income from medical practice pooled and distributed to its members according to some pre-arranged plan." They recognize the fact, as already mentioned above, that the words "institute, academy, clinic, group, or medical center" and the like, when used in advertising, appeal to the public and even to other doctors in the profession. However, these signs are frequently misleading when applied to groups or organizations of physicians engaged in the practice of medicine. To clarify the situation and meet with medical approval, all such groups should be defined in the same category and subject to the same Code of Ethics as that which governs the individual practitioner of medicine. The Chicago Medical Society passed a resolution authorizing their Public Relations Committee to study the use of signs indicating clinics, medical centers and the like, and to define these names and suggest regulatory measures in connection with the use of these signs.

In some partnerships, clinics, or group practices, a doctor will come into the group and work for one year on a salary, or until it is determined whether he wants to become a part of the group or whether the group considers that he is suitable for work with the group. Then he goes on a percentage or a salary plus a percentage, or bonus, according to the agreement with the whole group.

So far as private clinics owned by doctors themselves are concerned, the crux of the situation remains that the same laws and ethics which apply to the private physician apply to these clinics.

This is the third in a series of articles by Dr. Davison
on medical ethics.

physician's bookshelf



Books Received

Hewitt, Richard M., M.D., *The Physician-Writer's Handbook, Tricks of the Trade of Medical Writing*, W. B. Saunders Company, Philadelphia, 195, 415 pp., 37 figs., \$9.00.

Nadas, Alexander S., M.D., *Pediatric Cardiology*, W. B. Saunders Company, Philadelphia, 1957, 587 pp., 343 figs., \$12.00.

Beierwaltes, William H., M.D.; Philip C. Johnson, M.D., and Arthur J. Solari, M.S., *Clinical Use of Radioisotopes*, W. B. Saunders Company, Philadelphia, 1957, 456 pp., 126 figs., \$11.50.

Bauer, W. W., M.D., *Official A.M.A. Book of Health*, Dell Publishing Co., Inc., New York, 1956, 320 pp., \$3.50.

Ham, Thomas Hale, B.S., M.D., *A Syllabus of Laboratory Examinations in Clinical Diagnosis*, Harvard University Press, Cambridge, 1956, 496 pp.

Laird, William R., M.D., *The Philosophy of Medicine*, Education Foundation, Inc., Charleston, W. Va., 1956, 64 pp., \$3.00.

Conn, Howard F., M.D. (editor), *Current Therapy 1957, Latest Approved Methods of Treatment for the Practicing Physician*, W. B. Saunders Company, Philadelphia, 1957, 731 pp., \$11.00.

Barnes, Josephine, D.M., F.R.C.S. (Eng.), F.R.C.O.G., *The Care of the Expectant Mother*, Philosophical Library, New York, 1956, 270 pp., \$7.50.

Reviews

Stokes, Dillard, **SOCIAL SECURITY—FACT AND FANCY**, Henry Regnery Company, Chicago, 1956, 198 pages, \$4.00.

This is required reading for anyone interested in the recent amendments to the Social Security Law. The book takes a conservative point of view and pokes holes through, in, and around the social security program.

Dillard Stokes maintains the social security program is not a form of insurance but a form of relief, its payments not a premium but a tax. He says it is inequitable in its benefits, discriminatory as to who receives them, and in short, he concludes the social security program is a fraud.

This is a strong position, but the book takes great pains in making a clear explanation of all aspects of the program and gives wonderful sample cases of various recipients under the social security program.

A quote from William Graham Sumner in the preface of the book will give you a good idea of the type of approach and thinking of the author.

"As soon as A observes something which seems to him to be wrong, from which X is suffering, A talks it over with B, and A and B then propose to get a law passed to remedy the evil and help X. Their law always proposes to determine what C shall do for X or in the better case, what A, B, and C shall do for X. As for A and B, who get a law to make themselves do for X what they are willing to do for him,

we have nothing to say except that they might better have done it without any law, but what I want to do is look up C. I want to show you what manner of man he is. I call him the Forgotten Man. Perhaps the appellation is not strictly correct. He is the man who is never thought of. He is the victim of the reformer, social speculator and philanthropist, and I hope to show you that before I get through that he desires your notice both for his character and for the many burdens which are laid upon him."

Harry, Ralph G., F.R.I.C., **COSMETICS, THEIR PRINCIPLES AND PRACTICES**, Chemical Publishing Company, Inc., New York, 1956, 786 pages, \$17.00.

This book is a voluminous (786 pages) comprehensive compilation of cosmetic recipes. The author is a British chemist, pharmacologist, and physiologist and has had competent assistance. Each phase of the discussion is supported by pro and con quotes from the literature. In fact the book is practically one quote after another. The author will often sum up a chapter, such as in nutrition of the skin he states that "in our present state of knowledge we have no evidence that the skin can be nourished by external means." Under cosmetics and aging of the skin he states that cosmetic preparations by minimizing the loss of lubricating oils, delay the onset of wrinkling and thus delay the premature aging of normal skin.

The author is on firmer ground when he discusses the various cosmetics. His chapters on permanent wave solutions are extremely interesting and complete. In his opinion Ammonium thioglycollate waving preparations prepared along the lines specified in the Evans McDonough patents are safe when used according to the directions given and represent no undue dermatological hazard. He has chapters on perfumes, hair lotions, hair dyes, tooth paste, eye lotion, foot preparations, and bath preparations.

The book's primary purpose is to tell others how to manufacture cosmetics. Great amount of detail is gone into as to how to pack creams, lotions, what temperatures they can stand, their shelf life, and transportation ability.

In view of the fact that cosmetics are used literally from the cradle to the grave and physicians are often asked to voice an opinion, this book will at least tell the physician what is in the product he is to discuss. The dermatologist will use it for among other reasons tracking down allergens, in which it should be an invaluable aid.

Some of us will not agree with the author's statement that cosmetics are not harmful to the skin and are always beneficial; whether normal skin needs any cosmetics other than in a desire to decorate it is a debatable question.

The author is not a clinician but the clinician may find some new ideas in this wealth of technical data.

Vincent J. Cirincione, M.D.

THE ASSOCIATION

MAG Council Meeting

March 9 and 10, 1957, Radium Springs

Council Chairman George R. Dillinger called the meeting of the Council of the Medical Association of Georgia to order at 2:50 p.m., March 9, 1957, Radium Springs Resort, Albany, Georgia.

Officers and councilors present included: Hal M. Davison, Atlanta, President; Carl C. Aven, Atlanta, 1st Vice-President; David Henry Poer, Atlanta, Secretary; Thomas W. Goodwin, Augusta, House of Delegates Speaker; Lee Howard, Sr., Savannah, 1st District Councilor; George R. Dillinger, Thomasville, Chairman, 2nd District Councilor; J. G. McDaniel, Atlanta, 5th District Councilor; George H. Alexander, Forsyth, 6th District Vice-Councilor, serving as Councilor in the absence of Henry H. Tift, Macon; F. G. Eldridge, Valdosta, 8th District Councilor; and Charles R. Andrews, Canton, 9th District Councilor.

Vice-Councilors present included: J. Z. McDaniel, Albany, 2nd District; Charles S. Jones, Atlanta, 5th District; and James M. Hicks, Brunswick, 8th District.

Also in attendance were Chris J. McLoughlin, Chairman, Public Service Committee; Charles Hock, Augusta, President, Richmond County Medical Society; W. Frank McKemie, President, Dougherty County Medical Society; Thomas D. Johnson, Albany, member, Dougherty County Medical Society, and Messrs. Milton D. Krueger and John F. Kiser of the Headquarters Office staff.

Minutes—The minutes of the following Council and Executive Committee of Council meetings were read: (1) Council, December 15-16, 1956, Bon Air Hotel, Augusta, and on motion duly made and seconded, it was approved that the minutes include authorization for the Executive Committee of Council to remit a 1956 Christmas Honorarium to Edgar Woody, Jr., Editor of the *JMAG*. These minutes as corrected were approved. (2) Executive Committee of Council conference phone call, January 8, 1957, (3) Executive Committee of Council conference phone call, January 8, 1957, and (4) Executive Committee of Council conference phone call, January 23, 1957, and these minutes, as read, were approved. (5) Special meeting of Council, January 27, 1957, Dempsey Hotel, Macon, and on motion duly made and seconded two corrections were approved as follows: (a) That a motion reading in the minutes "Dr. Davison then moved (Davison-Goodwin) that the Chairman of Council of the Medical Association of Georgia appoint a five-man committee, with the President and Chairman of Council as ex-officio members, to recommend to the Council what is considered ethical and legal by the MAG . . ." be corrected to read "Dr. Davison then moved (Davison-Goodwin) that the Chairman of the Council of the Medical Association of Georgia appoint a five-man Committee with the President and Chairman of Council as additional members, to recommend to the Council what is considered ethical and legal by the MAG . . ." and, (b) That the date for the Executive Committee of Council meeting reading "February 15 or 16 was selected . . ." be changed to read "February 16 or 17 was selected . . .". With these corrections, the minutes were approved. (6) Executive

Committee of Council, February 16, 1957, Academy of Medicine, Atlanta; these minutes were approved as read.

Veterans Affairs Report—The report of Hartwell Joiner, Gainesville, Chairman of the MAG Veterans Affairs Committee, on the AMA Veterans Affairs Committee meeting held January 26, 1957, Chicago, was read:

Reports from the VA Committee to the Medical Association of Georgia in regards to the meeting. They have decided to have what they call regional meetings now, taking in smaller areas of the United States and getting problems and suggestions. Dr. Orr, the AMA Chairman of this committee felt that it would be more effective, and he will be able to get all discussions in the one-day meeting. (1) The general opinion is that as fast as we come up with some success in proper legislation in regards to medical care to Veterans, Congress seems to get two or more bills to offset it. (2) There is still in the legislation the proposal to build additional VA beds as we now have more than 60 per cent of the present bed capacity occupied by Veterans. (3) There is still an inacceptable and inexcusable way in getting Veterans admitted to hospitals who need emergency care or prompt care for disability as regards to service connection. (4) A strong suggestion that we continue the so-called home program of veterans. (5) There is a wide-spread opinion that we should put pressure on our representatives to allow local hospitals to take care of veterans who are going to be paid for by the VA and (6) The request that we, in some way, make state surveys of as many hospitals as necessary to determine how many veterans secure care at the local hospitals.

It was moved that Dr. Joiner be requested to carry out the recommendations in his report and report on these recommendations for action at the April 27, 1957, MAG Council meeting Savannah. Motion approved.

It was moved that the sum of \$300.00 be appropriated from the Reserve Fund for the Veterans Affairs Committee to conduct a survey per the recommendations in Dr. Joiner's report. Motion approved.

AMEF Committee Report—A report by Ben K. Looper, Chairman of the MAG American Medical Education Foundation Committee, was read.

Interprofessional Council Report—Chris J. McLoughlin, Chairman of the Interprofessional Council, reported on the activity of the Council and their recent February 10, 1957 meeting held in Atlanta.

Salk Polio Vaccine Committee—Chris J. McLoughlin read a report submitted by Don F. Cathcart, Atlanta, Chairman of the MAG Salk Polio Vaccine Committee. Dr. McLoughlin reported on the publicity campaign, citing the Governor's proclamation, the newspaper, church, and PTA cooperation, and then discussed a letter on this matter to be sent to all MAG members. It was moved that in the all-member mailing Council's name be used in recommending that physicians charge from \$3.00 to \$5.00 for the first polio shot given during the week of April 1-8, 1957, which is the week of the MAG Salk Polio Campaign. Motion approved.

AMA Medical Education and Licensure—David Henry Poer reported for Charles F. Stone, of the MAG Education Committee, on the 53rd Annual Congress on Medical Education and Licensure held February 10-12, 1957, Chicago. Dr. Poer discussed internships, postgraduate education, residency problems, training programs, and gave a resume of the meeting.

Medicare—Charles S. Jones, Chairman of the Medicare Review Board, reported on the progress and activity in implementing the Dependents' Medical Care Act, Public Law 569. Discussion ensued.

GP of the Award and Hardman Award — Mr. Krueger reviewed the mechanics of making the "GP of the Year" award and the "Hardman Award". It was generally agreed that the "GP of the Year" award would be handled in this manner: Council will receive nominations for "The GP of the Year", these nominations will be presented at the first meeting of the House of Delegates (April 28) and nominations from the floor will be asked for; from these nominations the House of Delegates will elect the "GP of the Year".

After discussion of the presentation mechanics of the "Hardman Award", it was moved that the Chairman of Council appoint a committee of Council to receive and present nominations to the House of Delegates which will elect the Hardman Award recipient. Motion approved. The chairman appointed W. G. Elliott, Chairman; F. G. Eldridge, and George H. Alexander.

Council Finance Committee Report — J. G. McDaniel, Chairman of the Finance Committee, reviewed the budget and stated that, as of February 28, 1957, the budget was in fairly good order.

Dr. McDaniel reported that the Association mimeograph machine was in need of replacement. It was moved that a new mimeograph machine be purchased, for a sum not to exceed \$800.00, from the Reserve Fund.

1957 Annual Session Report — J. G. McDaniel, Chairman of the Council Annual Session Committee, reported that almost all of the arrangements for the 1957 Annual Session April 28-May 1, Savannah, were completed. He emphasized that there would be 20 out-of-state guest speakers, 50 in-state guest speakers, many social activities, and of course, the business of the Association conducted at this meeting. He presented a tentative budget as stipulated by the Council. The budget showed *approximately* \$11,610.00 expense connected with the meeting, and it was brought to the attention of Council that only \$10,000.00 had been budgeted. It was moved that this *tentative* budget be accepted and approved.

Medical Defense Privileges — Chairman Dillinger called on Hal M. Davison to report on a matter concerning the defense of an MAG member which was filed prior to the May 15, 1956, change in medical defense privileges. The case was tried in court after May 15, 1956, and there was some controversy as to whether the defense of this case came under the old (prior to May 15, 1956) Constitution and By-Laws coverage for medical defense, or should come under the provisions of the current Constitution and By-Laws. Dr. Davison then cited the Executive Committee of Council action February 16, 1957, on this same matter, in which it was agreed that this member was covered by the present Constitution and By-Laws and that the Association should then assume no more than the \$100.00 charge per the current Constitution and By-Laws. Dr. Poer reviewed the whole situation and the correspondence and the old Constitution and By-Laws was read and discussed. It was moved that a Council reference committee consider this problem and report back to the Council at the reconvened meeting (March 10). This motion was approved, and the Chairman of Council appointed Charles Andrews, chairman; George Alexander and J. G. McDaniel, as members of this reference committee to study this problem and advise Council.

Evidence in Medical Testimony — Chairman Dillinger

called on Mr. Kiser to present certain legal data concerning a malpractice case under review by the Georgia Supreme Court as cited in the *Journal of the Medical Association of Georgia*, February 1957 issue, page 72. It was brought out that if this decision is upheld, future negligence cases could be decided without expert medical testimony. It was moved that the Council authorize up to \$150 for the filing of an *amicus curiae* brief by the Association legal counsel, Mr. John Dunaway, and that this expense be charged to the Medical Defense Committee. Motion approved.

MAG Headquarters Building Committee Report — Chairman Dillinger called on Carl C. Aven, Chairman of the Council Committee on Headquarters Building who reported that two meetings of his committee had been held jointly with the Executive Committee of the Board of Trustees of Fulton County Medical Society and the Building and Planning Committee of Fulton County Medical Society and the Building and Planning Committee of Fulton County Medical Society on January 22, 1957, and March 6, 1957. He further reported as a result of these meetings that the matter rests now with the Building and Planning Committee of the Fulton County Medical Society which will meet in the near future to consider further the problem of headquarters building space for the MAG.

History of Medicine Committee Report — Chairman Dillinger called on Carl C. Aven, special appointee of the President to study a work in progress by the History and Vital Statistics Committee Chairman, J. Calvin Weaver, in the publication of a book covering the history of medicine in Georgia. Dr. Aven reported that he had given much time to a study of this data with Dr. Weaver and gave a complete report on the costs of publication of such a book. As publication was not imminent at this time, no action was required, however it was recommended that a typist be paid up to \$100 to aid Dr. Weaver in preparing manuscripts and to further aid in the re-typing of the manuscripts already completed by the Headquarters Office. This appropriation of up to \$100 was to be charged to the Reserve Fund. Motion approved.

By general agreement, a vote of thanks was given to Dr. McDaniel, Albany, and Dr. McKemie, Albany, for their wonderful hospitality on the occasion of this meeting. The Chairman called the meeting recessed until 8:30 a.m., March 10.

March 10, 1957—reconvened

CHAIRMAN DILLINGER called the reconvened meeting of the Council of the Medical Association of Georgia, March 9-10, 1957, Radium Springs Resort, Albany, Georgia, to order at 9:15 a.m., March 10, 1957.

In addition to the Council members attending March 9th was W. G. Elliott, Cuthbert, 3rd District Councillor.

Medical Defense Privileges Reference Committee Report — Charles Andrews, Chairman of the special Council Reference Committee on Medical Defense Privileges, reported. Dr. Andrews discussed the matter from both points of view; cited the old Constitution and By-Laws of the Association, and reread the present Constitution and By-Laws. The reference committee recommended that the Medical Defense Committee negotiate with Mr. Dunaway to arrive at a more suitable agreement and also arrive at an agreement for future

cases similar to this so that the matter could be settled to the mutual satisfaction of all.

It was moved that this matter be referred to the Chairman of the Medical Defense Committee for recommendation to Executive Committee of Council which would then authorize action on this problem. This motion was then approved.

Institution-Physician Relations Committee Report — George H. Alexander reported for Henry H. Tift, Chairman of Council Institution-Physician Relations Committee. He read Dr. Tift's report of February 26, 1957, and Mr. Krueger read a suggested change submitted by J. Frank Walker, member of the committee. By general agreement, Council altered the last paragraph of this report, and it was moved that the report be approved and that a copy be sent to everyone who was sent a questionnaire, and that the correction as recommended by Council in the last paragraph be made. This motion was approved, and the corrected report is as follows:

In the spring of 1956 questionnaires concerning the relationship between the hospitals of Georgia and radiologists, pathologists, and anesthesiologists were sent to these groups of specialists in Georgia and to 224 hospital administrators. Replies were received from approximately 20 per cent of the hospitals, 25 per cent of the anesthesiologists, 30 per cent of the radiologists, and 50 per cent of the pathologists. The replies were tabulated and a complete summary is attached to this report.

The replies to the questionnaires were studied, discussed, and summarized by the committee.

It is apparent from this survey that some physicians in Georgia are employed by private hospitals on a straight salary basis. In the opinion of the committee such an arrangement constitutes the corporate practice of medicine and lends itself to exploitation of physicians by hospitals. It is considered unethical for a physician to have this type of arrangement with a hospital that admits private patients. (This, of course, does not apply to internes and residents.)

It is common practice in two of the specialties concerned in these questionnaires, i.e. radiology and pathology, for a physician to have an employment contract with a private hospital whereby the physician receives a certain percentage of the receipts of his department. It is considered ethical for a physician to have this type of arrangement with a hospital if: (1) he makes certain that there is sufficient professional coverage at all times to assure high quality and efficient service, and (2) provided that the hospital bill clearly indicates that a percentage of the fee is for professional service. (In the interest of maintaining patient-physician relationship, it is desirable to have the name of the physician concerned on the hospital bill, although it is realized that it is not always feasible, particularly for larger hospitals.)

The committee feels very strongly that the same rules of ethics should apply to all physicians of Georgia.

Legislative Committee Report — Eustace A. Allen, Vice-chairman of the MAG Legislative Committee, reported on the meetings and activity of the Legislative Committee. Mr. Kiser presented additional data and brought to the attention of the Council some of the problems inherent in legislative activity.

By general agreement, and at the recommendation of the Chairman of Council, it was moved and duly seconded that the MAG Legislative Committee and Mr. John F. Kiser be commended for their fine activity in behalf of the Association.

Peach Belt Medical Society Professional Conduct Problem — David Henry Poer reviewed a situation involving members of the Peach Belt Medical Society and the resultant action of that Society's Grievance Committee. It was moved that this problem be referred

to the Association's Professional Conduct Committee for recommendation and that their recommendation be presented to the Council at the April 27 meeting. Motion approved.

State Board Appointments — David Henry Poer reported on the status of certain appointments to State Boards.

Medical School Ethics — J. G. McDaniel, Chairman of the Special Council Committee on Medical School Ethics, presented his report in the form of a document titled "Application in Certain Cases of Principles of Ethics of the American Medical Association as Adopted by the Medical Association of Georgia Council Special Medical School Ethics Committee".

Dr. Davison reported on the background of this document, and it was thoroughly discussed and emphasized by Dr. Davison that this document was based on the AMA House of Delegates action. Drs. Poer, Hock, Goodwin, Jones, et al, discussed this document.

It was moved that the Special Medical School Ethics Committee report be adopted, paragraph by paragraph, and approved as a whole and referred to the House of Delegates as a part of the Council report. This motion was approved, and after an ensuing paragraph by paragraph adoption of the report with a minor change in one paragraph and the deletion of certain sub-paragraphs proposed covering instrumentation of the plan, the document was adopted as a whole and is recorded herein as follows as adopted:

APPLICATION IN CERTAIN CASES OF PRINCIPLES OF ETHICS OF AMERICAN MEDICAL ASSOCIATION AS ADOPTED BY MEDICAL ASSOCIATION OF GEORGIA COUNCIL SPECIAL MEDICAL SCHOOL OF ETHICS COMMITTEE

The House of Delegates of the American Medical Association, in June of 1956, adopted the report of the Council on Medical Services, stating at the same time what the American Medical Association considers desirable concerning the practice of medicine by the faculty of a medical school, and second, what the Association considers ethical.

Whatever produces good feeling between an institution, its graduates, local doctors and doctors in the area it serves is desirable.

The House of Delegates of the Medical Association of Georgia accepts the principle expressed in this report of the Council on Medical Services of the American Medical Association and expresses in definite terms what is considered desirable and what will be considered ethical by the Medical Association of Georgia concerning the practice of medicine by the faculties of medical schools in the State of Georgia.

1. It is preferable that teachers who are heads of departments in medical colleges should be full-time professors, should not have private patients, and should receive all of their remuneration from a salary paid by the institution. Such professors spend their entire time in teaching, in research, and in the care of the indigent sick in the institution.

2. If for any reason these heads of departments do have private patients, they become part-time teachers just as are those others who spend part of their time in teaching, in research, and part of their time in practice on private patients, and who spend all of their time for practice, teaching and research in the facilities of the institution and its associated institutions.

3. No college, hospital or other institution shall practice medicine. This means that the institution must not share in any way or have any interest in fees collected for professional services. This means also that the institution shall not control or direct the doctor in his private practice or interfere in any way with the doctor-patient relationship.

4. No funds created by fees from the practice of

medicine by faculty members shall accrue to the general budget of the institution.

Hospitals

The hospital of a teaching institution should be used primarily for teaching purposes and not as part of a public welfare department in the care of the indigent patients not suitable for teaching nor for custodial care of the chronically ill. The hospital of a teaching institution must not be used for the profit of the institution.

Hospitals attached to teaching institutions preferably should be limited to the number of beds required for teaching purposes, or at least should not be so large that the administration must use all possible means to keep it full.

Patients

1. All patients admitted to the hospitals of medical schools and to the clinics attached to medical schools, whether paying, medically indigent, or indigent, must be referred in writing by their private physicians, or in the case of indigent patients by some agency recognized as having authority to do so. Private, pay patients must be referred only by their regular physicians and then only in writing.

2. All patients, pay or non-pay, admitted to teaching hospitals should be used for teaching purposes and should be selected as having value from this standpoint.

3. Free choice of physician must be retained and patients may be referred to or may select a specific doctor. If the patient be referred to the institution, then he must be referred by some administrative official to the chief of the department he belongs in, who will either care for the patient himself or will in turn refer him to some other doctor in his department. Patients must not be referred to individual doctors by any member of the administrative staff of the hospital. The patient must be assigned to a physician who is responsible for his care.

4. If consultations with other doctors are necessary for diagnosis or for outlining treatment, the patient may be referred to other doctors in the hospital or clinic unless either the referring doctor or the patient has expressed a preference for other consultants.

5. If operative procedures are found to be necessary, unless it is a matter of emergency, either the patient should be sent back to his own doctor who in consultation with the patient will decide where and by whom the patient will be operated on, or the physician should be consulted by phone. In event the patient requests operation in the hospital, the referring doctor should be consulted by phone, notified of the patient's decision and invited to be present at the operation.

6. It creates good feeling if the referring doctors are invited to visit their patients and are allowed to examine their charts while they are in the hospital.

7. Patients must be sent back to the referring doctor with a full report of the findings, diagnosis, and suggestions for treatment.

Time Consumed in Private Practice

Private practice by salaried teachers of medical colleges, teachers in hospitals or clinics associated with medical colleges, must never interfere with their teaching or research responsibilities. The relative time used for private practice and for other duties in the medical college must be agreed upon and from time to time, must be rigidly checked by the dean as of contractual relation between the medical school and the doctor individually.

Various methods have been used for limiting the time to be used in private practice.

1. Actual percentage of time allowed expressed in hours, days, or parts of days per week.

2. By accepting referred patients only.

3. By limiting the number of beds allowed in the hospital for any one doctor.

4. By limiting the amount that any teacher may earn in private practice, expressed in actual dollars or in percentage of his income.

Finances

1. Charges for the services of teachers should conform to those customary in the community, as rendered by doctors of like standing, experience and ability.

2. Charges must be made by the doctor who rendered the service.

3. Charges must be collected by the doctor who rendered the service or by a central office, but in the name of the doctor who rendered the service or of a partnership of licensed doctors but not in the name of a corporation or of any person or group of persons not licensed to practice medicine.

4. Fees collected for a doctor must be credited to the account of the doctor who rendered the service or to his department as may be agreed upon by the doctor himself.

5. Teachers having a private practice in any institution must be charged for all expenses incurred by the institution in furnishing the facilities used in their practice if legal, and these charges must be commensurate with charges for similar services paid by other doctors in the community.

6. After the above charges are deducted, there remains a net fee fund in the name of the doctor or of the department to which he belongs. The disposition of this net fee fund must be under the control of the doctor or doctors whose services produced it. This fund must not be disposed of by contract with an institution nor by direction of the institution.

If the disposition of the fund is a matter of more than one doctor in the medical school or a department of the school, it must be distributed according to an agreement between the doctors themselves totally uncontrolled by the medical school, but with the knowledge of the dean.

(a) Part or all of the net fee fund may be used to pay or to enhance the salaries of the doctors.

(b) Part or all of the net fee fund may be assigned for academic enrichment in the department, for instance, for research, for equipment, and for travel of teachers, fellows, or residents to medical meetings or for observation and study of work in other institutions, which these doctors otherwise could not afford.

(c) At the end of the year any net fee funds not expended by the above means may, with the consent of the doctors in the department, be donated to a general research fund for which the head of any department may apply. This fund must be administered by a committee composed of the doctors earning the professional fees, with the advice of dean.

Relation of Faculties to Medical Societies

Faculty members should be members of their local society and should take an active part in the proceedings of both their county society and the state society.

Liaison Committees

1. (a) *County Society*: a liaison committee should be appointed by the local county society or societies to work with the dean and/or a committee from the faculty of each medical college in this area.

(b) *State Association*: a liaison committee should be appointed by the council of the state association to work with the dean and/or a committee from the faculty of each medical college in the state. If the school be a state school, each region or district of the state should be represented and members of the various specialties in medicine should be included. Also, each state committee should have at least one member from the local county society. In general, it is wise to include on these committees some doctors who are graduates of the school and some who are not graduates of the school.

2. *Meetings*: these committees to be of service must be kept active, and the colleges must cooperate with them. They should meet at regular intervals, at least every six months, and on call for special meetings by the dean or committee chairman or by a majority of the members of the committee. A definite number of times a year should be decided upon and adhered to for regular meetings.

3. When a medical school is contemplating some change in its policies which may cause controversies or antagonism of other doctors of the community or of the state, or of the area which it serves, the dean of the school should confer with the liaison committee, clear the action with them, and have them present the matter to their respective societies before the change is inaugurated.

4. All controversies should be settled as quickly as possible by a conference between the school authorities and the local and state liaison committees. When and if it is evident that they can't be settled by the local and state liaison committees, help should be requested of the Council of the State Association which may in turn request assistance from the appropriate committee of the American Medical Association.

Publicity

The publicity emanating from a medical school or from a clinic attached to a medical school should be in good taste, of a type which has the approval of the local medical community, and must conform to the ethics of the American Medical Association. There should be no release to lay publications mentioning the names of individual doctors in connection with medical or organizational achievements except as may be of interest in alumni publications of the school itself.

Council Special Committee on Medical School Ethics

J. G. MCDANIEL, Atlanta, *Chairman*
CHARLES S. JONES, Atlanta
HAL M. DAVISON, Atlanta
CHARLES R. ANDREWS, Canton
LEE HOWARD, SR., Savannah
GEORGE R. DILLINGER, Thomasville
CLARENCE B. PALMER, Covington

It was moved that the Council of the Medical Association of Georgia thank the Richmond County Medical Society for its efforts in working out the differences in the Talmadge Hospital controversy, stating that Council appreciates the efforts that went into the formation of the revised Waters' Resolution, and that Council further resolve that the purposes stated in the revised Waters' Resolution are compatible with those stated in the principles approved by Council this date; and it was further moved that it is the Council's opinion that the revised Waters' Resolution represents one method by which this controversy can be solved on a local level. Motion approved.

Franklin-Hart Medical Society Charter—Mr. Krueger presented a letter from Morris N. Dalton, Secretary-Treasurer of the newly formed Franklin-Hart Medical Society, requesting that a charter be issued to this organization by the Council. This request was the result of a unanimous vote of a February 27 organizational meeting of the former Franklin County Medical Society and the former Hart County Medical Society at which meeting it was proposed and duly acted on and approved that the two societies join together in forming the Franklin-Hart Medical Society. It was moved that the Council of the Medical Association of Georgia grant a charter this date to the newly formed Franklin-Hart Medical Society. Motion approved.

AMA Medical-Legal Symposium—Mr. Kiser announced the program of the March 15-16, 1957, AMA Medical-Legal Symposium to be held at the Atlanta Biltmore Hotel.

Industrial Health Meeting Report—Mr. Krueger presented a report for Allen M. Collinsworth, MAG Representative of the Industrial Health Committee attending the meeting of the 17th Annual Congress on Industrial Health held February 4-6, 1957, San Francisco.

New Business—(1) Chairman Dillinger asked President Davison to preside, and Dr. Davison then called on Dr. Dillinger to discuss the finances of the Association. The deficit and additional indebtedness to be incurred by the Association was discussed, and it was emphasized that the Council should seriously consider this matter.

Drs. Poer, McDaniel, Howard, and Mr. Krueger discussed certain fiscal items of importance.

It was moved that the problems of Association income and deficit be referred to the Finance Committee for their report and recommendation to the Council at the April 27 meeting. Motion approved.

(2) Dr. Dillinger then took the chair, and it was moved that Council establish a committee to study the Association committee set-up and make recommendations along the lines of the AMA committee organization, if found adaptable, and further that this same committee study the duties of the vice-president and make recommendations.

(3) It was moved that the Secretary of the Association be instructed to write a letter to J. W. Chambers expressing the Council's pleasure on his recovery and bringing him up-to-date on Council and Association activity. Motion approved.

(4) It was moved that the local physicians be thanked by the Council for their cooperation and that the Council again express its appreciation to Dr. McDaniel and Dr. McKemie for their hospitality on the occasion of this Council meeting.

(5) By general agreement, it was approved that the date of the next Council meeting be 7:30 p.m., April 27, Hotel DeSoto, Savannah.

(6) By general agreement, it was approved by the members of the Executive Committee that the date of the next Executive Committee meeting be April 14, 1957, Atlanta.

There being no further business the meeting was adjourned at 1:15 p.m.

Executive Committee of Council

Medical Defense Privileges—Per the March 9-10 MAG Council recommendation and request to have the Medical Defense Committee review medical defense privileges under the old and new Constitution and By-Laws, and further to have the Chairman of the Medical Defense Committee make a recommendation to the Executive Committee of Council which would then approve and authorize action on this problem, the Medical Defense Committee meeting March 14, 1956, recommended the following which was approved by Drs. Davison, Poer, Dillinger and McDaniel (majority of Executive Committee):

(1) That the Medical Association of Georgia is obligated under the privileges of Medical Defense cited in the MAG Constitution and By-Laws prior to May 15, 1956, to bear the cost of defense of those cases deemed worthy of defense which have been filed prior to May 15, 1956.

(2) That the Medical Defense Committee of the MAG assume responsibility in gathering medical data on these cases filed prior to May 15, 1956, and meet with the MAG Attorney and the physicians involved in these cases to resolve these cases with the least expense.

(3) That the MAG Counsel attempt to abstain in all these cases where the Association Counsel is not the principle attorney in the case, thereby minimizing the expense to the MAG.

(4) That the Association Counsel attempt to keep his participation in these cases on a consultation basis and further attempt to keep cost and fees incurred to a minimum.

This was explained to the MAG Attorney, and Mr. Krueger was instructed to notify parties concerned of this ruling.

Rural Health Committee

March 3, 1957, Atlanta

CHAIRMAN J. L. Walker, Clarkesville, called the meeting of the MAG Rural Health Committee to order at 2 p.m., March 3, 1957, Academy of Medicine, Atlanta.

Committee members present included: J. L. Walker, Clarkesville, Chairman; Charles T. Brown, Guyton; M. F. Arnold, Hawkinsville; T. A. Sappington, Thomaston; John P. Heard, Decatur; H. C. Derrick, Lafayette; and H. B. Cason, Warrenton. Also present was Mr. Milton Krueger, Atlanta, MAG Executive Secretary.

Chairman Walker reviewed rural health items discussed in a meeting with the AMA Rural Health Council Director, Mr. Aubrey Gates. This conference, held March 3, 1957 with Mr. Gates and Miss Lucile Higginbotham, Rural Education Specialist, Agricultural Extension Service of the University of Georgia, concerned the following items:

(1) *Preceptorships*—Chairman Walker called on Maurice F. Arnold to report on the progress of the Georgia Academy of General Practice in establishing preceptorships at both medical schools in Georgia. Dr. Arnold reported that a GAGP committee would meet in March and subsequently meet with the deans of both medical schools. Chairman Walker then assigned Dr. Arnold the responsibility of liaison between the Rural Health Committee and the GAGP Preceptorship Committee, and requested that Dr. Arnold report at the next meeting of the Rural Health Committee on this project.

(2) *GP Lectures at Medical Colleges*—Chairman Walker reported that he had been given due study and consideration to the establishment of a series of lectures on the advantages and problems of general practice, and that he would report further on this at a later date.

(3) *Family Physician*—Chairman Walker discussed the importance of the family physician, and it was moved that the chairman of the Committee on Rural Health be instructed to write all the county medical society presidents and secretaries recommending that they advise the public to seek medical advice from the family physician and to consider the family physician a medical counselor. Motion approved.

(4) *Paramedical Recruitment*—Chairman Walker reported on the practical nurses training by the Vocational Department of the State Board of Education and gave information on the progress in this area of training. He appointed John P. Heard to investigate and compose a booklet for high school students on paramedical careers.

(5) Mr. Krueger reported on the progress of "Junior-Senior Day" programs at the Medical College of Georgia and Emory University School of Medicine for 1957. Maurice F. Arnold was appointed Chairman



Rural Health Committee Meeting

Pictured left to right are T. A. Sappington, Thomaston; H. C. Derrick, Lafayette; Hugh B. Cason, Warrenton; Charles T. Brown, Guyton; J. L. Walker, Clarkesville; M. F. Arnold, Hawkinsville; and John P. Heard, Decatur.

of the Medical College of Georgia program, and H. C. Derrick was appointed to handle the Emory program with assistance from Dr. Heard. Tentative programming was discussed.

(6) *Physician Placement*—The problem of Physician Placement in organizing locations seeking physicians and physicians seeking locations was discussed. By general agreement, it was understood that the Rural Health Committee member from each District would be responsible for ascertaining the need of a location for a physician with the assistance of Mr. John F. Kiser of the Headquarters Office. It was further recommended that Mr. Kiser organize and handle the paper work in operating an effective physicians placement bureau, and that he be responsible for working with the Rural Health member in each district.

(7) Chairman Walker reported on the need for an advisory board to the MAG Rural Health Committee, and after general discussion it was agreed that such an advisory committee be appointed by the chairman and that this committee should probably be composed of two representatives of the Farm Bureau, four representatives of the Agricultural Extension Service, and one representative of the Georgia Council on Churches. It was moved that the Rural Health Committee meet with this Advisory Board as appointed by the chairman sometime in mid-April 1957, and it was emphasized that all members of the Rural Health Committee would attend this meeting, probably to be held in Athens. Motion approved.

The chairman then called for unfinished business, and there being none, called for new business and there being none, the meeting was adjourned at 3:45 p.m.

MAG membership dues were payable January 1, 1957. Those members whose dues were not paid by April 1, 1957, are considered delinquent. If you are among those, pay your dues to your county society secretary now.

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyrighted, 1957, by the Medical Association of Georgia, 875 West Peachtree Street, N.E., Atlanta 9, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; \$1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.

Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

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The Executive Secretary's **LETTER**

HIGHLIGHTS OF THE *103RD ANNUAL SESSION

SOCIAL SECURITY for physicians, the corporate practice of medicine, "Medicare," and a raise in dues were some of the many issues receiving official action at the *103rd Annual Session of the Medical Association of Georgia, April 28-May 1, Hotel DeSoto, Savannah.

W. Bruce Schaefer of Toccoa was installed as president, succeeding Hal M. Davison of Atlanta, and Lee Howard of Savannah was named president-elect.

David Henry Poer, Atlanta, was succeeded after six years as secretary-treasurer by Chris J. McLoughlin, also of Atlanta. The new 1st vice-president is T. A. Peterson of Savannah, and Hugh Bickerstaff of Columbus was named 2nd vice-president.

Other new officers include Charles T. Brown, Guyton, First District councilor (formerly vice-councilor), Charles R. Andrews, Ninth District Councilor, and A. W. Simpson, Washington, who became Tenth District Councilor succeeding Harry L. Cheves of Union Point.

House of Delegates

Ninety-four delegates from 44 component medical societies convened at the First Session of the House of Delegates, Sunday, April 28, to consider 52 reports, eight addendums to reports, and 22 resolutions. Five reference committees met on Monday and reported their findings to the House on Tuesday afternoon.

Social Security

The House of Delegates deferred action on two resolutions regarding social security—one recommending physicians' inclusion under the program and one recommending that physicians oppose the program.

After a joint meeting of two reference committees and speeches by the director of the AMA Law Department, Mr. Stetler, and a representative of the Social Security Administration, the House voted to defer action on this matter until the entire membership can be polled concerning their individual views as follows:

"The Secretary of each county medical society shall be instructed to poll the active dues-paying members of the society. . . . Cards shall have a statement that: 'Since doctors cannot be covered on a voluntary basis by social security, do you favor coverage of doctors by compulsory social security?' . . . Cards are to be furnished to Council, and Council is requested to act on this matter through proper

channels in accordance with the will of the majority of the ballots."

The Delegates also urged active support by members of the Jenkins-Keogh Bill, providing pension rights for the self-employed.

"Medicare"

Several resolutions and reports mentioned the new "Medicare" program, as administered by the Headquarters Office of the MAG. Two resolutions recommended that Council study the possibility of subcontracting the fiscal administration of the program, but these were both disapproved and the substitute resolution which follows was adopted:

"WHEREAS, the operation of the Medicare program by the central Headquarters Office of the MAG presents many problems, and

"WHEREAS, the program has been in operation for so short a time that it is difficult to evaluate the administration of this program,

"NOW THEREFORE BE IT RESOLVED, that the Medicare program be continued in its present form until a more adequate evaluation of this program has been obtained."

Another resolution that was adopted recommended the following:

"MAG hereby declares that anesthesiology, pathology, radiology, and physical medicine are practices of medicine under the terms of the contract which has been negotiated between the MAG and the Department of Defense" known as the Medicare program.

Dues Raised \$15.00

A reference committee recommendation that dues of the Association be raised from \$25.00 per year to \$40.00 was approved by the House of Delegates.

In its report, the committee noted "that the Association is now in deficit spending and recommended that the dues be increased by the sum of \$15.00 per year."

Neither the officers' reports nor the report of Council had made a specific request for additional funds, but the fact that the Association is currently operating on a deficit budget was mentioned in several reports.

Emory Clinic

The House of Delegates approved an agreement drawn up by attorneys for the MAG and the Emory Clinic which it was felt will help to resolve any differences or misunderstandings which might have existed between the MAG and the University in regard to the operation of the Clinic.

The resolution, as it was approved by the Delegates, is as follows in part:

"WHEREAS the Association's Special Counsel reports that an agreement has been reached satisfactory to Emory University and to Emory University Clinic during the past six months, and

"WHEREAS the said agreement embodies the following terms and arrangements:

"(a) The University and the Clinic will take care in the future that publicity will not issue from the university which refers in any way to 'Emory University Clinic,' except as would be appropriate in announcing organizational changes or other facts in formal university publications;

"(b) The University and Clinic will remove written provisions in the agreement between them which, in the past, might have given the impression that the University did or could control the private practice of the members of the Clinic;

"(c) The University and the Clinic will limit payments from the Clinic to the University for facilities furnished to a fair and reasonable charge. The University will not have a direct interest in the earnings of the Clinic;

"THEREFORE BE IT RESOLVED, that the Medical Association of Georgia approves the said agreement as conforming to legal and ethical principles.

"BE IT FURTHER RESOLVED, that the Committee on Medical Education work with Emory University and Emory University Clinic in the implementation of the new agreements and arrangements to the end that there may continue among the Medical Association of Georgia, Emory University, and Emory University Clinic a close, constructive cooperation."

Special Medical School Ethics Report

The delegates also approved a special code of ethics to be applied in cases involving teaching institutions where problems of the corporate practice of medicine are concerned. This was the recommendation of the Special Council Committee on Medical School Ethics.

The full title of this document is "Application in Certain Cases of Principles of Ethics of the American Medical Association as adopted by the Medical Association of Georgia Council Special Medical School Ethics Committee."

It was felt that this document would serve in the future as a guide for local medical societies. According to the document, the report "expresses in definite terms what is considered desirable and what will be considered ethical by the Medical Association of Georgia concerning the practice of medicine by the faculties of medical schools in the State of Georgia."

The "Waters Resolution"

Considerable discussion at the House of Delegates second session centered around the Waters Resolution. The Richmond County Medical Society delega-

tion urged full approval and endorsement of the resolution which outlined certain changes in the operational policies of the Eugene Talmadge Memorial Hospital.

A revised Waters Resolution was given full approval and endorsement by the delegates. "Comments" in the resolution were deleted and the section relating to fees was altered to read as follows:

"FEES—Patients coming under categories of dire emergencies and unusual circumstances who are financially able to pay shall be rendered a hospital bill commensurate with the hospital charges in this area.

"The question of professional fees shall be settled finally in regard to legal matters by attorneys representing the Medical Association of Georgia and the Board of Regents; and the question of medical ethics shall be settled by the Council of the Medical Association of Georgia. It is requested that Council be directed to instruct its attorneys to consult with the attorneys of the Board of Regents and the Attorney General to finally settle this question legally."

Miscellaneous Action

In other action the House of Delegates called on the AMA to study and survey the Blue Shield-Blue Cross Plans on a national level "in reference to physician-patient relationship, physician-hospital relationship, and discrimination, if any, in contracts to patients, to physicians and to hospitals"; urged enactment of a model commitment law in Georgia in regard to the hospitalization of the mentally ill; requested the Governor to establish a Commission on Nursing to study the present critical shortage of nurses in the state; disapproved the construction of new VA hospitals and additional beds in Georgia and other states, unless "it can be proved that actual need exists for the care of service connected disabilities, true bona fide emergencies, and care for such needy or medically indigent veterans who are without income or property beyond their basic needs"; urged that hospital staffs and hospital administrators in Georgia "look upon alcoholism as a medical problem, to admit cooperative alcoholic patients for treatment and to help these patients and their families understand the need for early and adequate treatment as would be done for patients with any other illness."

Thomas W. Goodwin, Augusta, and Fred H. Simonton, Chickamauga, served as speaker and vice-speaker of the House respectively. Reference committee chairmen and secretaries were: David R. Thomas, Jr., chairman, and Virgil B. Williams, secretary; E. C. McMillan, chairman, and Charles T. Cowart, secretary; T. A. Sappington, chairman, and A. V. Gafford, secretary; Rafe Banks, Jr., chairman, and James A. Green, secretary; H. G. Davis, chairman, and H. E. Weems, secretary.

Facilities for Care and Treatment of the Mentally Ill in Georgia

RIVES CHALMERS, M.D., Atlanta, Georgia

FACILITIES FOR care of the mentally ill in Georgia have traditionally consisted of our city and county jails and the state mental hospital at Milledgeville. In addition to these public facilities there have been private psychiatric hospitals and nursing homes providing care for those patients who were able to pay for hospitalization. The general hospitals of our states have not provided beds to care for mentally ill patients except in certain special instances, and there has usually been a definite policy to refuse admission to patients suffering with mental illness.

The increase in public interest for more adequate care and treatment for mentally ill persons which grew out of successful treatment of mental illness in the Armed Services during the war and the improved Veterans Administration Services to veterans suffering with mental illness resulted in organized efforts by community groups to develop psychiatric facilities for the mentally ill in certain of our local communities. The American Legion group in Savannah was most successful in this when they were able to establish an 11-bed psychiatric ward in St. Joseph's Hospital in Savannah. This ward was established in 1947, and during the first year of operation statistics prepared by the Savannah Association for Mental Health stated that there was a 50 per cent decrease in the admission rate to the State Hospital at Milledgeville as a result of the early hospitalization and treatment of mentally ill persons in the local general hospital. At this same time the Atlanta Association for Mental Health was instrumental in obtaining the designation of seven small rooms in the basement of the hospital building for Negroes at Grady Hospital. These were facilities for the mentally ill committed through the courts of Fulton and DeKalb Counties before being transferred to the State Hospital at Milledgeville. These facilities were never actually a part of Grady Hospital but were under

the direct supervision of the Sheriff of Fulton County. In this limited setting with psychiatric and medical assistance from the Departments of Psychiatry and Medicine at Grady Hospital, during the first five months of operation over half of all patients temporarily committed were able to return to the community rather than being committed to the State Hospital in Milledgeville.

At the same time as these experiences were being reported in Georgia, psychiatric groups throughout the United States were reporting the remarkable improvements in percentage of recovered patients and the shortened period of hospitalization necessary to produce recovery in those patients who were provided early diagnostic and intensive treatment procedures within their home communities; rather than being subjected to the frightening and degrading experience of being declared legally insane, placed in jail, and transported to a state hospital—removed from their home community by a representative of the sheriff's office in the same way that a criminal is banished to the state prison.

The advent of new pharmacologic methods for the treatment of mental illness, educational improvements for the more recent graduates of our medical schools, and postgraduate courses which can be used by the general practitioner as well as the specialist are all factors in creating a new vision of facilities now available for the care and treatment of mentally ill persons in our state. There is general recognition that the care and treatment of mental illness is just as much a responsibility of the general practitioner and family physician as pneumonia was 30 years ago. Doctors in all phases of medical practice are recognizing the fact that mental and emotional disturbances play a definite role in the illnesses of over half our patients, and the early symptoms of mental illness may be recognized in just the same way as the early symptoms of pneumonia or peptic ulcer.

The First Facility

Our present-day view of facilities for the care of the mentally ill begins with the offices of our family physicians. The Mental Health Committee of the Medical Association of Georgia is developing a program of continuing education to make available knowledge concerning the diagnosis, treatment, and rehabilitation of the mentally ill so that it can be used by each of us in our daily contact with patients in our practice. There is growing recognition among members of the psychiatric profession that the family physician is the first professional line of defense in the community against the initial onset of mental illness. Francis Braceland, President of the American Psychiatric Association, recently stated, "The key preventive agent in the entire mental health effort may well be the physician in community practice, for the physician in general practice sees every segment of the population, every age group, and persons at all economic and social levels. In his care of expectant mothers, in his obstetric work, in his care of babies and children, he may accomplish preventive psychiatry of heroic proportions." Fred W. Langer and Robert L. Garrard of North Carolina in a recent paper before the Tri-State Medical Society stated, "Psychiatry is moving out of the mental hospitals and into the community, and the general practitioner will practice more and more psychiatry. The most powerful and frequently used drug in general practice is the doctor himself. None of the miracle drugs can hope to prove more powerful than the interpersonal relationship between the doctor and the patient. This still remains the greatest single tool of psychiatry and one which is available to every physician. The wise family doctor knew this to be true before the word psychiatry was devised." These physicians also stated, "The general practitioner enjoys several strategic opportunities not shared by the psychiatrist. First, because of his closeness and position of confidence with the families in his community. — Second, in the treatment of emotional disorders he maintains a position of advantage over the psychiatrist in two significant areas: he is more intimately acquainted with the patient's total environment, and he sees the patient earlier in the development of the illness — the general practitioner has another great advantage in working with emotional illness in that he is more apt to talk the language of the patient and relatives. He usually knows the entire family and is able to ease anxiety and tension in other members who are threatened."

The Second Facility

Our next facility for the care of the mentally ill is one which as yet remains poorly developed in our state, but it is being given increased consideration in

communities throughout this state. This is the number of beds available for the care of psychiatric patients in general hospitals. Several large general hospitals in our state are now equipped with or are in the process of constructing units for psychiatric patients. These include the Eugene Talmadge Memorial Hospital in Augusta, the Macon City Hospital, the Columbus City Hospital, the new Grady Memorial Hospital in Atlanta, and the new Memorial Hospital of Chatham County in Savannah. In addition to this, the Division of Hospital Services in the State Health Department requires that new hospitals being constructed with Hill-Burton funds be equipped with at least one room specially constructed for the care of persons suffering with mental illness.

The community mental health clinic is recognized today as an essential to the preventive aspects of a mental health program. The Division of Health Conservation Services in the State Department of Public Health in cooperation with local health departments has established mental health clinics in Savannah, Macon, and Atlanta, and clinics are being planned for other communities in the state. These mental health clinics utilize the team approach consisting of psychiatrist, psychiatric social worker, and psychologist working closely together to provide diagnostic services, and treatment in certain selected cases in addition to consultative services with physicians and community agencies concerned with health. These services have been limited to children in most instances, but the plan of the State Health Department is to develop broader services available to all age groups in the population in order to promote the mental health of the community.

Our consideration of present-day facilities for the care and treatment of the mentally ill must necessarily recognize facilities still utilized for the large proportion of those citizens in our state who develop mental illness of such severity that they cannot be treated in their home communities and must be committed to the State Hospital. These facilities are the cells of our city and county jails where the individual must legally be held prisoner during the period of commitment usually lasting from three to 10 days. These facilities have no medical or psychiatric supervision, no nursing services available, and relegate the treatment of the person suffering with mental illness to persons responsible for the custody of persons charged with offense against the community.

The Lunacy Commission

The facility for determination of illness and decision as to admission to the hospital for treatment under our present law is vested in a Lunacy Commission established by the Ordinary of the County in which the person resides. The law requires the

Cycloplegia and the Optometrist

A Question of Malpractice for the M.D.

HOWARD F. HILL, M.D., RICHARD H. DENNIS, M.D.*

IT HAS BEEN brought to our attention that occasionally practicing physicians have been asked to administer cycloplegic medicine for optometrists so that the optometrist may then refract (fit glasses) to children and complicated refraction cases. It is also noted that certain M.D.'s do not know that optometrists are not medically trained and not legally allowed to use or prescribe medicine in any form. They are not doctors of medicine and only use the title of doctor because of state legislative action.

Although this has happened in only a few isolated instances, the dangers involved are considerable.

*Thayer Hospital, Waterville, Maine.

First, there are cases in which a cycloplegic may be disastrous; namely, in cases of glaucoma in which the patient might become blind. This is especially true of the narrow angle acute type of glaucoma in patients who may never have had a previous attack. This type of eye can only be safely recognized by a well trained ophthalmologist.

Secondly, malpractice suits against the optometrist would not apply, as he is not a doctor and did not prescribe the drug. The M.D. would bear the brunt of the legal action and rightly so.

Optometrists are not trained to the degree that they can judge the type of case needing cycloplegia, and the great majority of them realize this and do not compromise a friendly physician in this way.

.. Care and Treatment of the Mentally Ill (cont'd.)

ordinary to appoint a commission consisting of three people of whom two must be physicians if possible. The training of these physicians in diagnosis and treatment of mental illness is not specifically provided for in the law and remains a responsibility of the medical profession and the community at large.

The transportation facilities for mentally ill persons from our jails to our State Hospital are not under medical or psychiatric supervision, but rather are the direct responsibility of the sheriff of the county.

The facilities at our State Hospital in Milledgeville have been materially improved in recent years by an extensive building program and improvement in administrative management of the hospital. The fact that this facility is now so large that the population—including hospitalized patients, professional and non-professional personnel—totals approximately 14,000 people gives a clear indication of the tremendous problems involved in providing individual care and treatment for 12,000 of our citizens who are suffering with some form of mental illness. The hospital is operated under the direction of a psychiatrist, but he has only 40 physicians on his staff, of whom only two are certified in psychiatry by the American Board of Psychiatry and Neurology. Their task of maintaining relationships with 12,000 patients is practically impossible. This hospital has no residency training

program for psychiatrists, and consequently there is no reservoir to supply greater numbers of trained physicians. The nursing, psychological, and social work departments all operate under the severe limitations of staff and trained professional personnel observed in the psychiatric staff. It is a matter of public and professional knowledge today that no facility of this type, located at a remote distance from the homes and families of patients, with practically insurmountable problems of professional staffing as well as organization of treatment activities can hope to provide the caliber of diagnostic, treatment, and rehabilitation services necessary to those persons requiring hospitalization for mental illness in our state.

Conclusion

In conclusion, we recognize that the professional as well as the lay concept of facilities for care and treatment of the mentally ill have undergone a complete revision within the past 15 years. Our present view of facilities for the care of the mentally ill in our state extends from the office of the family physician to psychiatric beds in our general hospitals, community mental health clinics for prevention, and the State Mental Hospital at Milledgeville. We must still include our jails, lunacy commission, and county sheriffs.

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The Eye Signs of Leukemia

P. THOMAS MANCHESTER, JR., M.D. and GLENVILLE A. GIDDINGS, M.D., Atlanta, Georgia

OCULAR SYMPTOMS AND SIGNS may dominate the initial picture of leukemia. The most characteristic eye change is found in the retina. In two-thirds of the patients there is blurring of vision, and examination with the ophthalmoscope reveals a most unusual fundus picture. The entire retina is pale and often has a diagnostic faint green color. The arteries are also pale. The veins are engorged, and the disc margins are blurred. Leukocytic infiltration of the tissues produces wide streaks of white along the vessels, and the most unique finding is round white areas rimmed by a thin layer of red blood cells. This fundus picture is pathognomonic of the disease.¹

A common tumor of the lids and orbit is lymphoma. The presenting complaint of the patient may be exophthalmos which is either unilateral or bilateral. In the beginning, all blood studies may be negative, however, other evidences of leukemia usually appear within a short time. The occurrence of localized lymphomata without simultaneous evidence of constitutional blood disease is rare.² Patients with tumors of the orbit or lids should be studied for evidence of leukemia before any surgery is attempted.

Exophthalmos in leukemia is usually associated with the lymphocytic form of the disease.³ The patient to be described is unusual because she suffered from myelocytic leukemia. Duc, in 1937, and Wright, in 1938, reported instances of infiltration into the orbit complicating myelocytic leukemia, and Goldback, in 1933, also mentioned three possible cases in a paper dealing with leukemic retinitis.^{4,5,6}

Chronic infiltrations of the cornea and sclera, as well as conjunctival petechiae occur with leukemia, but they are of less diagnostic value. It is important to remember that leukemia is sometimes the cause of retrobulbar neuritis. Routine studies of patients with this condition should include a complete blood count and a blood smear.

Report of a Case

The patient was a 61-year-old woman who first noticed blurred vision in September 1955, during a brief attack of cardiac failure. She had suffered a heart attack four years before, but there was no evidence of leukemia then, as her white blood count was 12,050, and her blood smear was normal.

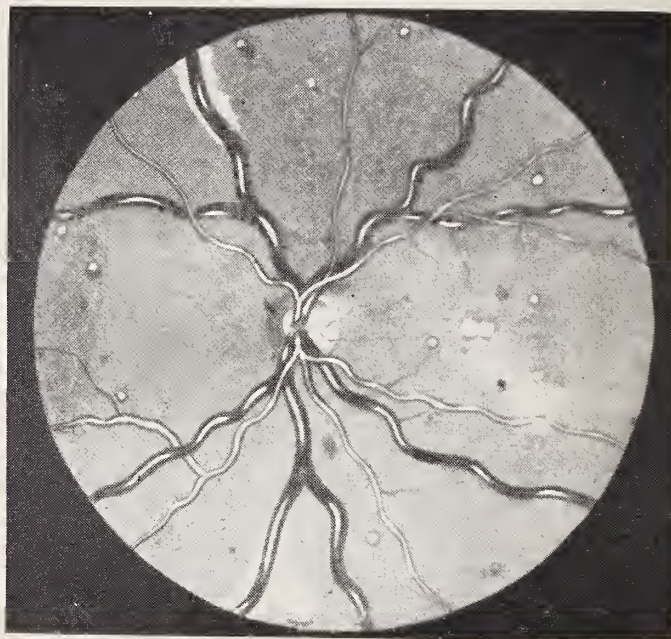


Figure 1
Ophthalmoscopic picture, left eye.

The vision became worse, and in December she reported for an eye examination. The corrected vision measured 20/100-1 in the right eye, and 20/100 in the left. Externally the eyes were normal. There was no exophthalmos then. Ophthalmoscopic examination revealed remarkable fundus pictures. (Figure 1) The most conspicuous feature was marked dilatation and tortuosity of the retinal veins. The arteries seemed of normal calibre. Scattered throughout the fundi were small white dots surrounded by thin rims of blood. These dots were of uniform size. In the macular areas there were accumulations of white material interspersed with splotches of blood. There were also many superficial hemorrhages everywhere. In the mid periphery there were conspicuous infiltrations of white fluffy material along the veins. There was no generalized pallor of the fundi, and the optic discs did not appear swollen as has been frequently described with leukemia. The differential diagnosis seemed to include severe anemia, leukemia, and septic choroiditis.

Blood studies by M. H. Freedman, M.D., revealed definite myelocytic leukemia. (Figure 2) (R.B.C. 2,407,000; Hb. 6.8; white cells 655,000 of which over 98 per cent were morphologically an embryonal type of the granulocytic series.) Improvement was rapid during treatment with myeleran and blood

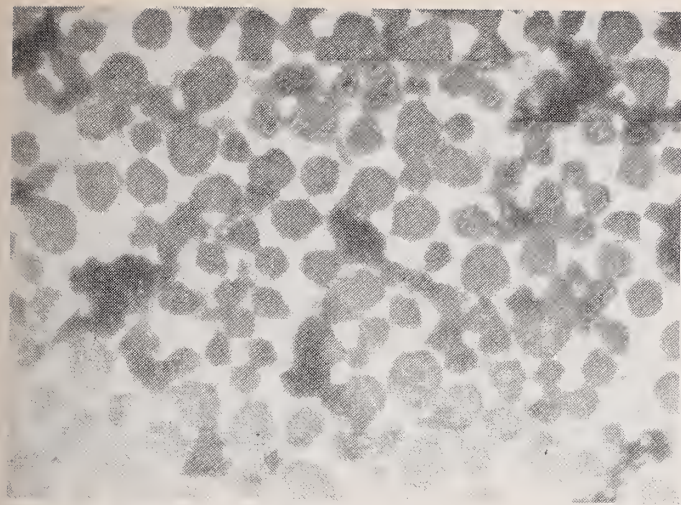


Figure 2

Blood picture showing abundance of primitive granulocytes.

transfusions. Fundus examination 24 days later showed a remarkable clearing of the retinopathy, although the vision remained 20/100 in each eye. There were no white areas anywhere, and the perivenous infiltrates had also disappeared. Many small hemorrhages were still present.

In February 1956, the patient returned complaining of pain around the right eye which had been present one week and which was getting progressively worse. There was no sudden onset as one would expect with an orbital hemorrhage. Diplopia developed sometime during that week.

Examination revealed exophthalmos of six mm. on the right; measuring 25 on that side and 19 on the other. (Figures 3 and 4) There was slight chemosis of the conjunctiva, but no evidence of bleeding. In the region of the upper border of the external rectus muscle was a bluish tumor mass extending posteriorly into the orbit. It was poorly circumscribed, and there was complete paralysis of the involved muscle. Clinically the condition resembled pseudo tumor of the orbit in the acute-

ness of its onset, the pain, and early extraocular paralysis. X-rays of the orbits and optic foramenae were negative. The family was very much opposed to a biopsy being performed, and this was not done.

On the assumption that the exophthalmos was caused by leukemic infiltration of the orbit, Roentgen therapy was started four days later. In the interim the pain around the eye became even more intense, finally demanding the prescription of demerol. During a period of eight days, 2250 Roentgen units were delivered to the orbit via three portals. Relief of the pain started four days after the irradiation was begun. Three weeks later the patient was completely comfortable and the exophthalmos had decreased from six mm. to only one mm. The external rectus paralysis continued and the mass in this region had not changed in its general appearance, although it seemed somewhat smaller.

Thirteen days later the patient was readmitted to the hospital because of rapidly developing cachexia, and this time she did not respond to treatment. She expired on April 13th.

Summary

A case of leukemic retinopathy and unilateral exophthalmos with myelocytic leukemia is presented. The exophthalmos rapidly resolved after radiation therapy.

478 Peachtree Street, N.E.

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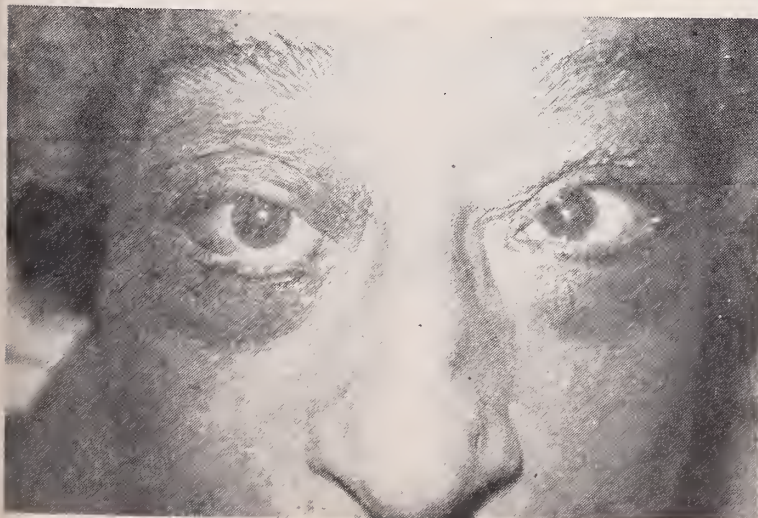


Figure 3

Paralysis of external rectus muscle. Patient is looking to the right.

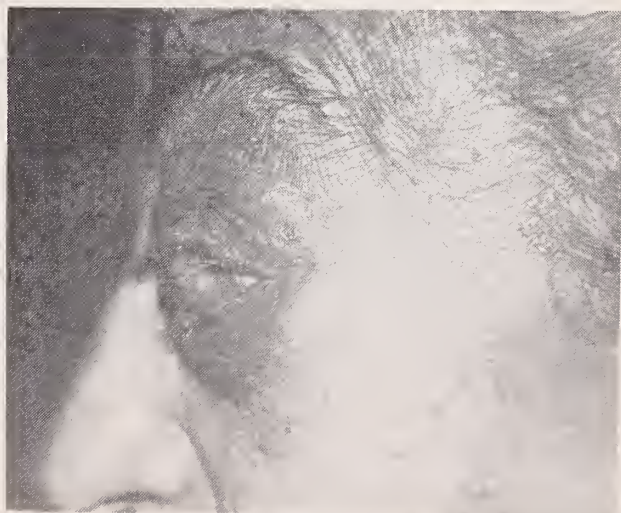


Figure 4

Exophthalmos, lateral view.

Mixed Mesodermal Tumors of the Uterus

JOHN E. SKANDALAKIS, M.D., MATTHEW WOOD, M.D., STERLING H. JERNIGAN, M.D.,
and WILLIAM J. PENDERGRAST, M.D., Atlanta, Georgia

MIXED MESODERMAL TUMORS of the uterus are very rare neoplasms of monodermal origin containing a mixture of mesodermal elements, i.e., cartilage, striated muscle, and other elements, arising from cells not normally present in the uterus. Because of their rarity, their poor prognosis and their pathological picture, it seems desirable that all such unusual neoplasms should be reported. Lebowich and Ehrlich¹² stated that "the recording of each new case is a medical obligation."

The credit for the description of the first case of mixed mesodermal tumors belongs either to Wagner²³ or to Guersant.⁷ Each author published a case in 1854. In 1867 Weber²⁴ presented a case which demonstrated the characteristic microscopic findings. Anderson and Erdmansonn² in 1870 reported the first case involving the body of the uterus. Thiede²² in 1877 emphasized the presence of cartilage and a myxomatous stroma, while Spiegelberg²¹ in 1879 gave an accurate description of the cellular elements and at the same time used the term "Weinbeeren." In 1892 Pfannestiel¹⁹ used the term "traubige sarkom." The term "mixed tumor" was proposed by Wilms²⁷ in 1899 and seven years later Kehrer¹⁰ first used the term "mixed mesodermal tumor." McFarland¹⁴ in 1935 reviewed the literature and found 116 different terms used to describe tumors which he felt should be classed together. He suggested the term "dyontogenetic," to include mixed tumors. In 1941 Glass and Goldsmith⁶ reviewed the literature and collected 59 cases of the corpus including two of their own, and 36 of the cervix up to that time.

Hardy and Moragues⁸ reviewed the literature from 1941 to 1950 and collected 21 cases of mixed tumor of the corpus, including two cases of their own. The confusion about the nomenclature continues. So, Creadick,⁴ (1954) although using the term "Sarcoma Botryoides," as a title on his paper, suggested that "the term dyontogenetic be used rather than a descriptive term plus the word sarcoma." The same author supported the idea that "the term mesodermal should not be used when obvious epithelial elements and myelinated nerve tissues have been observed."

The term "mixed mesodermal tumors" will be used, not because it is believed to be the correct one, but because it is universally accepted.

CASE I

A 61-year-old white female was admitted to Saint Joseph's Infirmary with a chief complaint of postmenopausal bleeding. She was apparently in a good state of health until one year prior to admission when she began to have what she thought was a recurrence of normal menstrual flow, having gone through the menopause at age 57. This abnormal bleeding was intermittent, occurring approximately every five weeks, being very similar to her previous menstrual periods in length of time, rate, and volume of flow. She would usually bleed approximately five days, then stop, and the bleeding would recur in about five weeks. Three months prior to admission her flow increased considerably, she began passing clots, and at the same time noticed a yellowish, foul-smelling vaginal discharge.

Family history was negative, and her history revealed no previous illnesses or operations. There were no exposures to radiation at any time. The review of systems was essentially normal.

A pelvic examination, on the day of admission, revealed a well supported perineum and a vagina full of necrotic bleeding tumor tissue. On speculum examination, it was noted that the mass was presenting through the cervical os.

Admission laboratory work was essentially normal. The day following admission, the patient was taken to the operating room and, under general anesthesia, a necrotic tumor mass was delivered in toto. The uterus was cleaned out thoroughly.

The day following surgery, the pathology report came back as follows: *Gross:* The specimen consists of eight large pieces of tissue which vary in size from the smallest, which measures approximately two cm. in diameter, to the largest which is ovoid in shape and measures 10 cm. in the longest diameter and six cm. across. This specimen is very necrotic and has a greenish color and a strong foul odor. It is friable in consistency, and on cut section through this portion it is shown to contain a large, jelly-like, red mass which appears to be a hematoma. *Microscopic:* Numerous representative sections show the soft gelatinous tissue to consist of spindle cells, which are yellow and which are separated from each other by much slightly blue staining material. The blue stain-

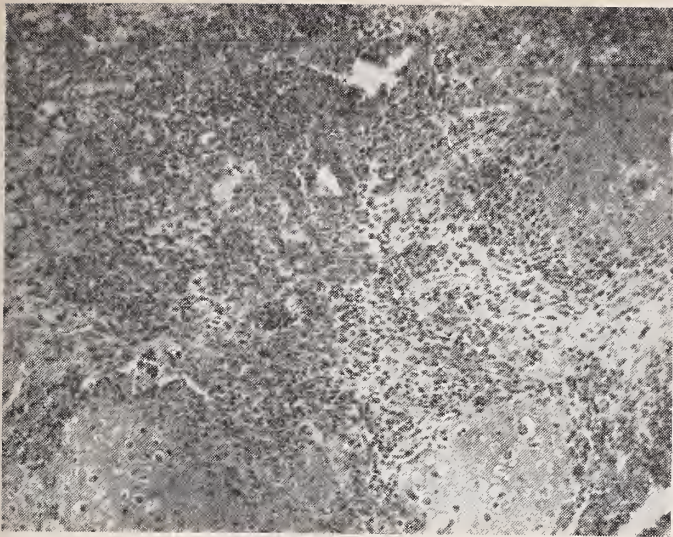


Figure 1

This figure represents the center of the tumor mass. There is a mixture of undifferentiated oval or spindle cells. Marked variation in cell size and shape is seen, as in early mesenchyma. The nuclei are prominent, and much of the cytoplasm insignificant. Most nuclei are diffusely scattered, but a few are in small clusters. The tendency to form hyaline cartilage is a distinctive feature of this particular tumor. This cartilage is plainly discernible, although it is not mature. It seems to blend imperceptibly with the surrounding undifferentiated tumor.

ing material is that of the stroma of myxomatous tissue. Mixed with the material though are many glands which resemble those of the endometrium. These have columnar cells not too well defined. There are also some islands of hyaline cartilage which is immature, although distinct. An occasional mitosis is in the specimen. There is no normal tissue in the specimen. Careful examination shows a few pink staining cells which are striated muscle cells. Striation is definite. The pathological diagnosis of mixed tumor of the uterus was made. (Figure 1)

In view of the pathological diagnosis, it was decided to do a total hysterectomy and a bilateral salpingo-oophorectomy. This procedure was carried out, and a fairly normal post-operative course ensued with no complications. She was discharged from the hospital asymptomatic.

The pathological report on the uterus, tubes, and ovaries at the time of her last surgery revealed the previously described microscopic findings except for the fact that in this specimen no definite striated muscle cells could be visualized. The cervix did not appear to be involved, and the tumor was coming down from the corpus, definitely arising in the uterine fundus. The tubes and the ovaries were unremarkable, and again a pathological diagnosis of mixed tumor was established. Patient was re-admitted approximately four months following surgery and a polypoid mass from the posterior wall of the vagina removed by cautery. This mass reported as an implant from the mixed tumor. After two and a half months the patient returned and at that time had marked abdominal distension, large right lower

quadrant mass, and a fixed tumor in the right pelvis by rectal examination. Within a few months this patient was dead. Autopsy was not performed.

CASE II

A 70-year-old white female, gravida 4, para 4, was admitted to the same institution with the chief complaint of post-menopausal bleeding. She had had her last menstrual period 25 years previously. Two months prior to admission she began to note bright red vaginal bleeding associated with a very gradual enlargement of the lower abdomen and some intermittent mild shooting pains over the pubis.

Her family history was non-contributory. Her past history revealed only an episode of acute nephritis 30 years previously. The review of systems revealed a good appetite but a loss of weight over a period of six months. On physical examination, the abdomen was found to be enlarged in the lower half with slight tenderness to palpation in the lower quadrants. The pelvic examination revealed a uterus about the size of a two to three month pregnancy and rather profuse bleeding from the cervical os. The clinical diagnosis was carcinoma of the uterine fundus. Her laboratory workup was normal. The day following admission, a large amount of friable tissue was removed per curette. Four tubes of radium were inserted into the uterine fundus, totaling 50 mg. in all. The pathological diagnosis was malignant mixed tumor of the uterus. All of the tissue was relatively undifferentiated, made of spindle cells, fused together in a loose syncytium. These cells had large dark nuclei. Many of them showed mitoses. There were areas of definite cartilage, which was of the embryonic type. (Figures 2 and 3)

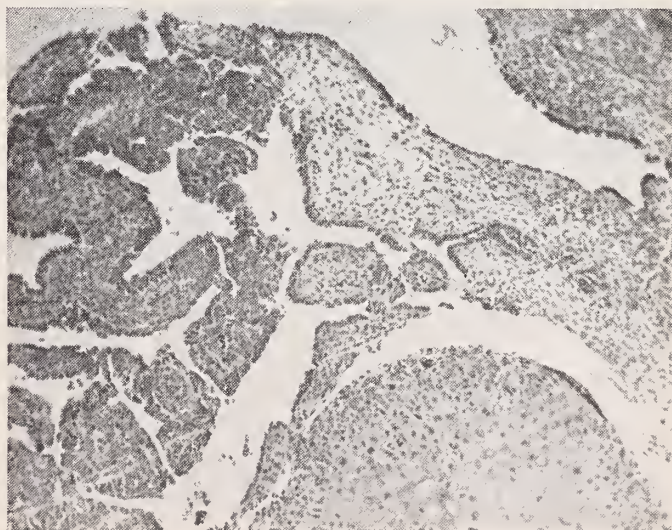


Figure 2

A picture of the tumor as it reaches the surface. Here are many papillae, some small and slender, others rounded and blunt. The glandular cells cover the papillae and participate in the hyperplasia. However, they do not present the same degree of anaplasia or activity as is found in the mesenchymal stroma.

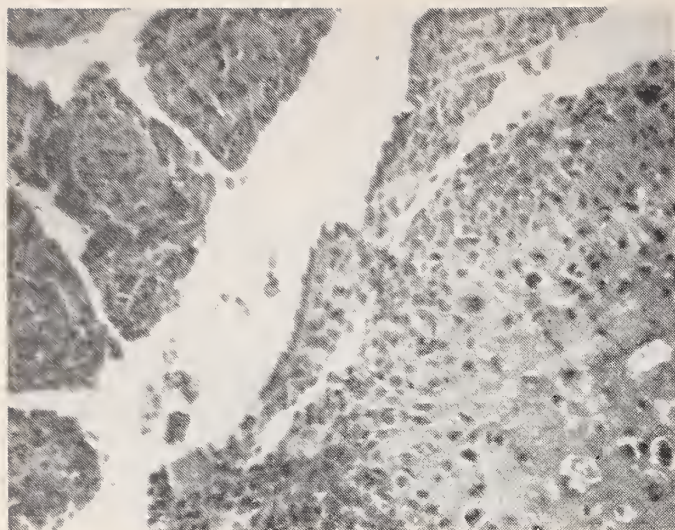


Figure 3

This is a higher magnification of the same field as is shown in Figure 2.

Six days after the admission, the patient was discharged but returned after one month with ascites, edema of the left leg, and generally with evidence of advanced metastatic disease. She was hospitalized for 20 days. The patient was readmitted two months later with clinical evidence of small bowel obstruction. She expired six days later, and an autopsy was performed on which "generalized sarcomatosis of the uterus and serosal surfaces with metastasis to liver, diaphragm and pleurae" was found.

Discussion

Pathology. 1. *Gross appearance.* The corporeal tumors are present as a polypoid mass and seldom grape-like. They have a gray-red color and they are smooth and friable. The tumors may be single or multiple, either pedunculated or sessile, large or small.

2. *Microscopic appearance.* A variety of elements have been reported in these tumors. These include: cellular sarcomatous tissue, cartilage, osteoid tissue, epithelial tissues, striated muscle fibres, smooth muscle fibers, myxomatous connective tissue, and lymphomatic tissue. No nerve tissue is ever found. Much variation of opinion exists among pathologists concerning the microscopic criteria to which a tumor must adhere before the diagnosis of "mixed mesodermal" is established.

The most rigid of these admission requirements are those of Lawen,¹¹ more recently propounded by Lebowich and Ehrlich¹² (1941), in which the demonstration of embryonal striated muscle cells in association with one or more heterotopic mesodermal elements must be present before the diagnosis can be substantiated. They stressed the fact that the presence of non-striated embryonal myoblasts *per se* does not qualify a uterine tumor as a mesodermal mixed type. Morehead and Bowman¹⁷ presented a

conflicting opinion in that they declined to exclude all but those containing striated myoblasts, since mesodermal mixed tumors are a pathological entity and a clinical group. Meikle¹⁵ and Shapiro²⁰ felt that early embryonic myoblasts could be present in which cross striations have not had time to develop. Hardy and Moragues⁸ reason that since metaplasia of smooth muscle into striated muscle has never been shown to occur, and since striated muscle is never seen in the uterus normally, then it may be maintained that the presence of two or more heterotopic elements in a tumor, whose gross structure and clinical characteristics are typical, is sufficient to support the diagnosis of mixed mesodermal tumors. Glass and Goldsmith⁶ support the less rigid position.

Classification. According to Hill and Miller,⁹ Meyer in 1920 classified these tumors in three types.

First. Combination tumor. True teratoma with malignant transformation of both epithelial and mesodermal tissues.

Second. Composition tumor. Sarcomatous change in the stroma of a carcinoma, or the reverse.

Third. Collision tumor. This is a coalescence of a separate and independent carcinoma and sarcoma.

We think that the best classification is that of Wilson et al.²⁸ Table I gives a word diagram with their opinion, which is indeed the answer to the confusion concerning these tumors.

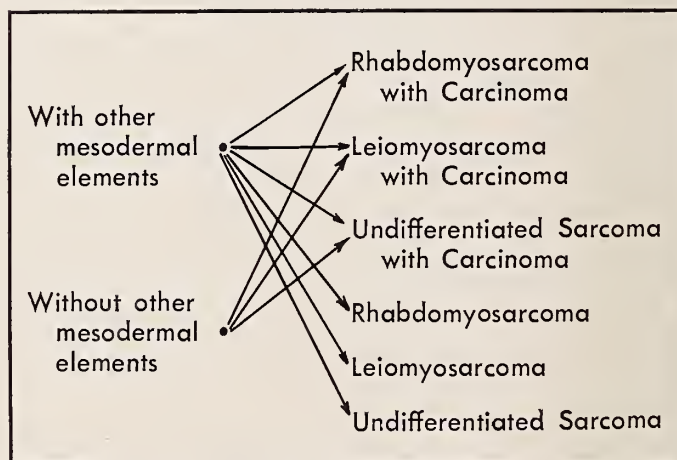


Table I

Word diagram of classification of Wilson et al.

Histogenesis. Considerable confusion has existed in regard to the histogenesis of these tumors. Suffice it to say at the present time there are two major theories as to their origin.

Pfannestiel¹⁹ in 1892 suggested the concept that these tumors arose from the endometrial stroma by a process of metaplasia. The second hypothesis is based on Cohnheim's theory of cell rest as elaborated by Wilms²⁷ in 1897. This idea holds that as the Wolffian duct grows caudalward in the embryo, it carries with it mesodermal cells which lie dormant for a time and later begin to multiply under an

unknown sarcogenic influence. It should be mentioned that neither of these theories provides an adequate explanation for the histogenesis of these tumors. The first theory does not explain the presence of striated muscle cells, and on the second theory the absence of striated muscle in the Wolfian body together with the development of the tumor outside the course of the Wolfian duct, controverts it.

Many well-known workers of our century support each one of these two theories. But even today no one can give a favorable answer as to the question concerning the presence of the muscle.

Clinical course. The most common presenting symptom is vaginal bleeding, frequently associated with a sanguinopurulent foul-smelling discharge, usually occurring in a woman past the menopause if of the corpus, and in young women, especially children, if of the cervix. This bleeding may range from spotting to profuse hemorrhage and is usually without specific pattern. Urinary symptoms early are unusual. Pressure symptoms and abdominal pain occur late in the course of this disease. If a mass is palpated on physical examination, it is usually freely movable. In a large percentage of cases a mixed tumor of the corpus will protrude through the cervical canal and into the vagina, presenting as a polypoid or grape-like mass.

An accurate diagnosis is seldom made without the aid of a microscope. There are not criteria or characteristic signs for these tumors. There is no report in the literature with a pre-operative or, better, pre-pathological diagnosis. Therefore there is not a clinical diagnosis but a microscopic one.

The incidence of mixed mesodermal tumors of the uterus can be appreciated by the following percentage relationships. (Table II)

Sarcoma of the Uterus*	75% Myometrial
	80% Pure Fibromyxosarcoma
	25% Endometrial
	Corporeal
	20% Mixed tumors**
	Cervical

*Represents 4.5% of all malignancies of the uterus and less than 1% of all uterine tumors.
**Glass and Goldsmith give a ratio between cervical and corporeal growths — 1 to 1.6.

Table II

For the cervical growths, which usually occur in young adults, the mean age is about 31 years.²⁶ Generally, both appear in women of all ages.¹

The prognosis is grave, and death usually ensues

within two years. The longest period of survival recorded is 10 years. Recurrence or local metastasis is frequent. In our first case, an implant was removed four months following panhysterectomy. In our second case, death occurred six months after the apparent onset of symptoms, with remote metastasis to the liver.

Treatment. The best mode of treatment is controversial. Radical pelvic surgery followed by deep X-ray, radiation alone, and surgery alone have all been tried. Despite the fact that these tumors are radio-resistant and occasionally appear to be stimulated by X-ray (unusual incidence of carcinosarcoma following irradiation illustrated by Hill and Miller⁹), the treatment of choice, if there is one, is radical abdominal surgery with post-operative radiation. Second look or repeated exploratory laparotomies are advisable.

Summary

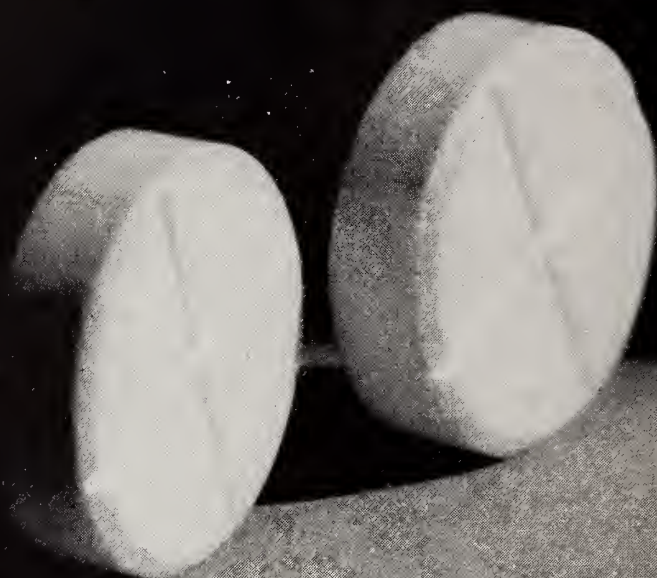
Two cases of mixed mesodermal tumors of the uterus are presented with a brief review of the literature. The diagnosis is seldom made pre-operatively. The clinical and pathological characteristics are described. Despite any treatment, the prognosis is always very grave.

Piedmont Hospital

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The Expanded Uses of Electrical Stimulation in Cardiac Resuscitation with a Suggested Plan for Its Routine Use in Acute Coronary Thrombosis

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THE RECENT DRAMATIC advances in cardiac resuscitation which have been popularized in both the lay and medical press have stimulated increased interest in the subject. The purpose of this article is to demonstrate the importance of having a machine for electrical stimulation of the myocardium available for instant use in all cases where cardiac arrest is anticipated, with particular emphasis in acute coronary thrombosis. The use of drugs or other procedures in cardiac resuscitation do not fall within the scope of this report. The three following cases illustrate the importance of its use in Morgagni-Stokes-Adams attacks, ventricular fibrillation, and cardiac stand-still.

"Douglas and Wagner¹ have reported the successful use of external electrical stimulation in the case of a 70-year-old male with a heart block. He had frequent attacks of unconsciousness and convulsions with a ventricular rate of 16. His heart did not respond to drugs, but did to external electrical stimulation. He was kept alive for seven days after which time his heart took over its regular beat." Two months later, at the time of the report, he had experienced no further trouble. Morgagni-Stokes-Adams attacks may be defined here as attacks produced by disease of the atrioventricular conduction system with resulting syncope because of prolonged asystole. They may or may not be accompanied by convulsive seizures.

Claude Beck and associates² reported the now famous case of a 65-year-old general practitioner who dropped dead from a coronary thrombosis as he was about to leave the hospital. In five minutes cardiac massage was begun through a thoracotomy. A guest lecturer discussing this case recently at Emory to illustrate the urgency of time, stated humorously that the surgeon was nice enough to open the patient's coat but that was all. He cut straight through the shirt and under-clothes barely missing his fountain

pen. The patient was found to have ventricular fibrillation which required electrical stimulation to control. The patient has since returned to active practice.

In Clinical Data³ is reported the case of a 70-year-old colored woman with tuberculous pericarditis. "She was being treated periodically at the hospital. On a recent visit, during treatment, she lost consciousness, became cyanotic, and there was no evidence of cardiac activity. Electrical stimulation was applied after about one and one-half minutes. She responded promptly. After 15 minutes electrical stimulation was discontinued, and she has had no further difficulty."

For this report cardiac resuscitation has been arbitrarily divided into two main groups—*Surgical*, the direct approach through a thoracotomy with massage, which facilitates the use of electrical stimulation and drugs. *Medical*—electrical stimulation applied externally by electrodes placed on the chest wall or by needles stuck through the chest into the myocardium to carry an electrical current or drugs.

In cardiac arrest the heart does one of two things, stands still or exhibits ventricular fibrillation. Both of these conditions are possibly amenable to the surgical approach with massage and electrical stimulation. Medically, at the time of this writing, only stand-still is amenable to external stimulation. The causes for surgical cardiac arrest aside from cardiac surgery as usually occurs in the operating room may be classified as follows:⁴ "Reflex phenomena, an overdose of, or sensitivity to, an anesthetic agent, hypoxia, or a combination of these factors. In the first group, due to reflex phenomena (vago-Vagal reflexes), if there is not too great a delay the heart will start up with a normal rhythm, as a rule after only a few moments of direct cardiac compression. In a second group (too much anesthesia), one has the simple problem of maintaining an artificial cir-

culation and respiration until the excess anesthetic agent is washed out of the system. The heart will then resume its normal activity. In the third group, when hypoxia is the primary cause of cardiac arrest, the problem is complicated by the fact that the brain and heart may have suffered considerable damage before the period of arrest actually began."

Cardiac arrests due to medical causes are usually situations where the heart supplies an inadequate amount of blood because of failure in the electrical system of the heart. Such conditions include³ complete heart block as in Morgagni-Stokes-Adams attacks, inadequate ventricular or nodal rhythms or ventricular tachycardia. Complete standstill may be precipitated by acute coronary thrombosis or trauma to the myocardium as may be produced by a needle during a pericardicentesis.

The thought of cardiac resuscitation has for some time held fascinating possibilities, but as long as it was a surgical procedure its principle usefulness was limited to the operating room. However, Zoll⁵ demonstrated in 1952, for the first time, that ventricular standstill could be successfully treated by electrical stimuli applied to the external chest wall. Many authorities believe that 70 per cent or more of the sudden deaths in acute coronary thrombosis are due to cardiac standstill—the remaining per cent to ventricular fibrillation.⁶ "When an area of myocardium is rendered ischemic, the resulting "trigger" may destroy the coordinated mechanism of the heart beat. A current of oxygen differential is produced across the zone of contact between red (normal) and blue (ischemic) myocardium resulting in "electric instability." In only a relatively small group can cardiac death be explained on the basis of the degree of reduction of total coronary inflow and extensive destruction of myocardium. In patients having "muscle death," the heart becomes hypodynamic and eventually fails. Presumably, little can be accomplished with respect to protecting these patients from death. However, in the much larger group who die of "mechanism death," destruction of the coordinated heart beat occurs in a heart with adequate total coronary inflow and functional myocardium."

This helps to explain the totally unpredictable prognosis of a coronary thrombosis attack. The extent of damage does not always parallel the ultimate outcome. It is believed that if an electrical stimulus were applied to the external chest wall, the heart beat would be restored in a great percentage of the cases. The heart muscle wants to beat and will beat if given a chance.

Two incidents happened recently in our hospital which illustrate the need for electrical stimulation to be available at all times as a new weapon in the



fight against the mortality of cardiac arrest. The first case involved an apparently healthy male in his third coronary day who was talking, and very much at ease, to a nurse on duty when he suddenly expired. The second patient had had an apparent coronary at the breakfast table in a local restaurant. He was being brought into the hospital on an ambulance cot when he too expired. It was felt that both of these patients might have been revived had electrical stimulation been available and applied in time.

A routine has been devised which is hoped will help to reduce the mortality in such cases. Our hospital secured an electrical Pacemaker.³ This machine costs a little over \$300.00. It is an essential piece of equipment and is practical for all hospitals or clinics to own. One of its many desirable features is that it requires no warm-up period. This is extremely important when every second counts. Since the instrument may be unused for many months and it would be impossible to charge for its true value if it did save a life, it was thought best to charge a stand-by fee, of perhaps 10 dollars for each patient who uses it on a stand-by basis. The machine is routinely placed by the bed in all coronary cases, or any case where cardiac arrest may be anticipated. Each nurse in charge of the floor is instructed in its operation. All the nurses have been given the following instructions if any coronary patient should expire suddenly and unexpectedly.

1. Have someone notify the doctor.
2. Apply electrodes within one minute.

3. Turn on machine and operate according to the instructions.

4. Start oxygen.

This routine was designed as simply as possible to make it instantly available for all patients who may need it. Certainly the impulse could be applied quicker if the machine were strapped to the patient's chest and turned on to the stand-by position. But this was not thought practical for the average patient of this type. However, any patient who exhibits arrhythmia, or in whom the chance of cardiac arrest appears greater than usual, should wear the electrodes with the machine attached until the crisis has passed.

For external stimulation to be successful, it should be begun in one minute or less. For internal stimulation, cardiac massage should be begun in four minutes or less. Even though the odds seem small to have the electrodes applied in one minute, there are many times when it is possible.

There is "nothing to lose and everything to gain in trying the Pacemaker. Particularly in cases of myocardial infarction. It has been well established that the Pacemaker can in no way injure the patient.

a. Exception: A very slight erythema appearing on the chest. This can be compared to a first-degree burn.

b. It has been established from reliable experimentation that the Pacemaker will not induce fibrillation. Fibrillation is a common result of electrocution when 0.1 to 2.0 amperes are passed through the heart. The Pacemaker, however, delivers only two milliamperes (.002 amperes) between electrodes." Therefore it is thought worthwhile to have a machine such as this routinely available in every hospital or clinic for us in the conditions I have described.

It has been suggested that every hospital have a resuscitation circuit in each operating room ready for instant use. The electrical impulse would emanate from one central source and would always be available.

This suggestion can be expanded further to include a circuit in every patient's room as well. If one had, for example in a large hospital, 20 coronary patients at one time, instead of needing about \$7,000 worth of resuscitation machines one would need only a few machines connected at a central point to distribute the electrical impulse to every patient's room. It would be highly improbable that more than one or two machines would be needed at one time.

Each potential cardiac arrest patient would only need electrodes and a remote control set to be properly covered.

Summary

1. Cases have been reviewed showing the use of

electrical stimulation in cardiac resuscitation for Morgagni-Stokes-Adams attacks, ventricular fibrillation, and cardiac standstill.

2. The arbitrary division—surgical and medical causes for cardiac arrest with their possible restoration have been outlined.

3. A theory of cardiac arrest in acute coronary thrombosis has been given.

4. The importance of having a machine available for cardiac electrical stimulation in all cases where cardiac arrest is anticipated has been shown.

5. Its routine use has definite possibilities of greatly decreasing the mortality from cardiac arrest, particularly in acute coronary thrombosis.

Addendum

Two important advancements have recently been reported.

(1) Dr. Paul M. Zoll⁸ of Beth Israel Hospital, Boston, has reported the development of an external defibrillator. This brings within possibility the restoration of the normal heart beat from both cardiac standstill and ventricular fibrillation without thoracotomy.

(2) A cardiac monitor⁹ is now available which will signal cardiac arrest and automatically begin external stimulation.

Subsequent experience by the author has shown the extreme importance of having a visible monitoring system while attempting to restore the normal heart beat. Its purchase along with any type of electrical resuscitation equipment is strongly recommended.

4 North Newton Street

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Right Middle Lobe Syndrome

ROBERT H. VAUGHAN, M.D., Columbus, Georgia

PATIENTS WHO HAVE RECURRENT episodes of pneumonitis involving predominantly one particular lung or lobe should be advised to have bronchoscopy and bronchography studies. Those foci involved with recurrent pneumonias usually represent bronchiectatic areas and regions of permanent lung damage, which certainly are not cured with antibiotic therapy. Their symptoms of pleurisy, productive cough, hemoptysis, and occasional high fevers are certainly ameliorated with bed rest and appropriate chemotherapy; however, the periodicity of these episodes warrants more consideration than repeated hospitalizations with supportive therapy.

Perhaps one of the most common sites of these recurrent pneumonias is in the right middle lobe. Several thoracic surgeons, Graham et al,¹ Brock,² and Paulson and Shaw,³ have ably described this syndrome of repeated right middle lobe pneumonitis. The pathological explanation for this is the fact that the right middle lobe bronchus is one of the longest and smallest in caliber of the bronchi, and the one that is most easily compressed by calcified old tuberculous lymph nodes, or by any inflammatory nodes which might be present in this area. As a consequence, the cleansing mechanism of this bronchus is interfered with, infection is encouraged, and

eventual irreversible bronchiectatic changes occur in the medial and lateral segmental bronchi of the right middle lobe. The story of recurrent right lower anterior chest pain with an associated cough, which may or may not be productive of purulent sputum, and hemoptysis is an all too familiar one. Routine films of the chest usually show a suggestive area of pneumonitis along the right lower border of the heart in the AP projection (Figure 1), and lateral films may well reveal a wedge-shaped area of what appears to be obstructive collapse involving the region of the right middle lobe (Figure 2). Bronchoscopic examination may reveal both chronic and acute bronchitis in the area of the right middle lobe orifice, and a narrowing of this bronchus. Bronchography will usually demonstrate the dilated bronchiectatic changes and the close grouping of the bronchi in this lobe, indicating evidence of obstructive collapse. The picture of actual involvement of the right middle lobe alone has been common enough to be labeled "the middle lobe syndrome."

The treatment for this condition, after its diagnosis has been documented by bronchoscopy and bronchogram, is a right middle lobe resection. The disappearance of the cough, the absence of the periodic attacks of pneumonitis and associated pleur-

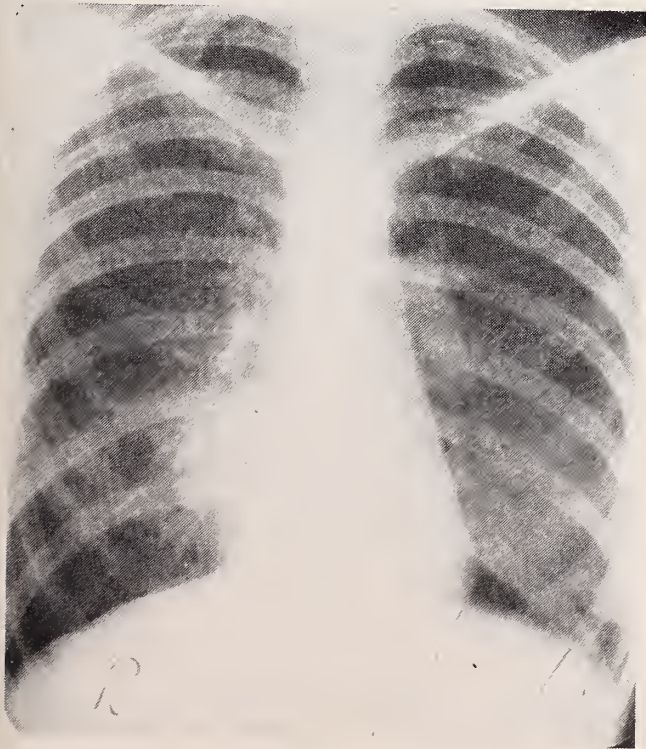


Figure 1

The right middle lobe pneumonitis (Case II) is easily seen on this film. This occurred during one of the patient's numerous bouts with infection.

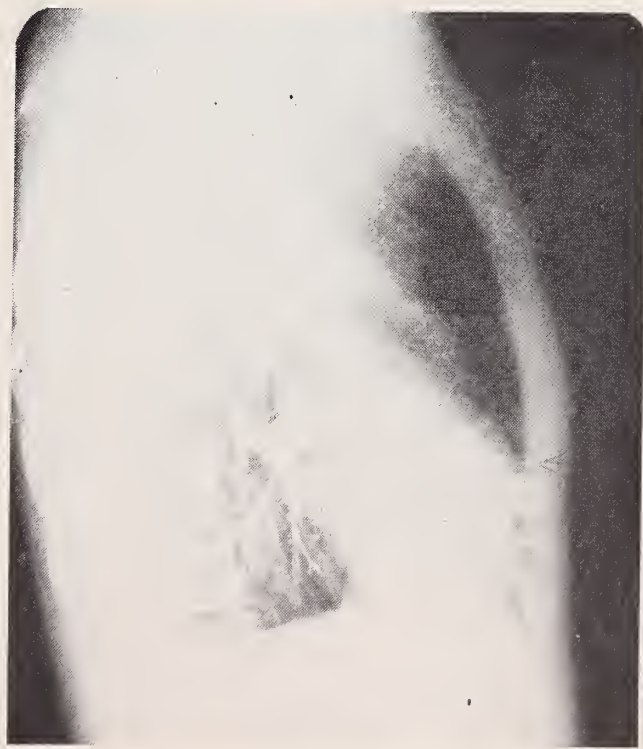


Figure 2

The lateral projection of the bronchogram (Case II) clearly shows the close grouping and cylindrical bronchiectasis in the right middle lobe.

isy, the increase in the feeling of general well-being, and usual weight increase, represent some of the gratifying results from this surgery. The following two cases are illustrative of the right middle lobe syndrome.

CASE I

Mrs. M. A., a 43-year-old white housewife and mother of four children, had had recurrent episodes of right-sided pneumonia since 1951. Several years ago she had a bronchoscopy and bronchograms with the findings consistent with bronchiectasis involving the right middle lobe. The patient elected to continue a conservative regimen and in the interim had at least three episodes of pneumonia with a persistent state of ill health, associated with a chronic cough, chest pain, and a constant feeling of malaise. She was re-bronchoscoped and bronchograms were repeated in November 1955; these again showed poor filling of the right middle lobe bronchus, with narrowing as well of this bronchus, and evidence of both chronic and acute bronchitis. The diagnosis of right middle lobe bronchiectasis was substantiated on examination of the films taken several years prior to this bronchoscopy, and the patient was offered excision of the right middle lobe. She accepted this, and on December 5, 1955, a middle lobe resection was performed. Except for a transient episode of vertigo, the patient has had a gratifying convalescence. She has gained approximately 15 pounds; her cough has disappeared, and she has had no recurrent episodes of pneumonia since her operation. Pathological examination revealed extensive bronchiectasis of the right middle lobe, associated with a nodal component of a Ghon complex. At the time of surgery there was a large firm lymph node compressing the right middle lobe bronchus, almost to the point of complete occlusion.

CASE II

Mrs. C. J. R., 35-year-old white housewife and mother of four children, has had four episodes of pneumonia during the past several years. These have for the most part always involved the area of the right middle lobe, and the films taken during these have shown evidence of what appears to be obstructive collapse involving this particular lobe. Bronchoscopic examination revealed some narrowing of the right middle lobe bronchus, as well as chronic and acute bronchitis in this area. Bronchograms (See Figure 2) done March 2, 1956, revealed evidence of tubular bronchiectasis involving all main elements in the right middle lobe. The remainder of the lung fields did not appear unusual. On March 27, 1956, a right middle lobectomy was performed and the patient's convalescence to date has been gratifying. She has gained approxi-

mately 10 pounds, and her cough has cleared. It is too early to completely evaluate her convalescence; however, she has had no episodes of pulmonary infection subsequent to her operation.

Pathological examination of this patient's specimen revealed evidence of bronchiectasis of the cylindrical type involving both segments of the right middle lobe, as well as evidence of obstructive collapse of this lobe. There was a large lymph node compressing the right middle lobe bronchus at its area of origin from the intermediate bronchus.

These two cases are illustrative of localized bronchiectasis and the results which can be obtained with adequate surgery. Certainly there are other portions of the lung which may be equally involved and from which similar results can be expected after proper resectional surgery has been done. Perhaps the reason for the middle lobe syndrome's recognition has been the fact that this bronchus is such a vulnerable one for compression and distortion. The early formation of the Ghon complex with the subsequent enlargement of the node in the area of the origin of the right middle lobe bronchus, its gradual compression and eventual almost complete occlusion is the explanation in part for the middle lobe bronchiectasis which develops in individuals who have this condition. The classical story of whooping cough and broncho-pneumonia secondary to measles or one of the other infectious diseases, with the ensuing history of bronchiectasis in one or both of the lower lobes does not necessarily obtain in this situation. This syndrome usually develops in later adult life, and the classical history associated with straight-forward bronchiectasis is lacking.

Summary

Patients who have repeated attacks of right-sided pneumonia, and particularly when it is in the area of the right middle lobe, should be referred for bronchoscopy and bronchography. These procedures can be done in a quiescent interval. They will often reveal a narrowing of the right middle lobe bronchus, evidence of chronic and acute bronchitis, as well as definite bronchiectasis or partial to complete blockage of the right middle lobe bronchus. The treatment for this condition is a right middle lobe resection. The results obtained from this surgery, where it is warranted, are gratifying.

203 Medical Arts Building

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A Further Report on the Treatment of Tic Douloureux with Stilbamidine

GEORGE W. SMITH, M.D., and JOSEPH M. MILLER, M.D., Augusta, Georgia

THE FIRST PATIENT to be treated for tic douloureux with stilbamidine was reported by the authors.¹ Subsequently, an account of 16 patients so treated was given.² Reports of the results obtained by others in the treatment of tic douloureux with stilbamidine have appeared.^{3,4} Since the last account,² the number of patients has increased to 109 treated intravenously and 114 orally.

Stilbamidine, 0.15 gram in 225 cc. of five per cent glucose in distilled water was given intravenously slowly daily for 14 days on an out-patient basis. Sixty-three patients of the group treated intravenously have been followed from 38 months to four months and are subject to assay. The remainder of the group receiving the drug intravenously were eliminated from the study at the present time because they were treated too recently. Fifty-seven patients were white and six Negro. Sixty-two obtained complete relief of their pain about two to five months after the start of treatment. Of these 62, 11 had an annoying paresthesia following the disappearance of the pain. One patient obtained about an 80 per cent relief. He continued to have pain and did not have the paresthesias consequent upon the administration of stilbamidine. Severance of the nerve subsequently did not relieve the pain, so some doubt was cast upon the diagnosis. He was counted a failure in drug therapy. Two patients had mild recurrences, one at 25 months and one at 32 months. Both patients had relief of their pain from the administration of stilbamidine orally, one at three days and one six days. The corneal reflexes were preserved in all patients.

The 11 patients with annoying paresthesias stated that they would rather have the paresthesias than the pain. All patients who obtain relief from pain will have paresthesias, but these were non-annoying in 52 patients. In general, the younger patients, the patients more stable emotionally, and Negroes will have milder degrees of paresthesia, which are non-disturbing.

The annoying paresthesias were itching, particularly around the eyes, and numbness or a leathery feeling of the face. The non-annoying paresthesias consisted of itching, formication, burning, usually of

the tongue and the buccal surface of the cheek, and a leathery feeling of the face.

Patients with tic douloureux without incapacitating hepatic and renal damage are candidates for treatment with stilbamidine. The administration of the drug should be strongly considered in the poor risk patient with heart disease or other medical condition contraindicating the performance of operation, in the elderly, in the failures of surgical treatment, in the patient with bilateral tic douloureux, and in the patient with one eye who contracts the disease on the same side.

One hundred fourteen patients were given stilbamidine, 0.13 grams, orally once a day for 14 days. The statistics in this group are not firm since the patients were treated only a short time ago. In general, however, about 60 per cent of the patients have had significant improvement as regards the number and severity of attacks but may have not obtained a complete remission.

Summary

Stilbamidine may be given with the necessary precautions to patients with tic douloureux. In total dosage of 2.1 grams over a period of 14 days, the drug is more than safe to be proposed as an alternative to operation. The great majority of patients treated intravenously obtained relief from pain, but a few were troubled by the paresthesias resulting from treatment. The possibility of troubling paresthesias must be explained to patients before they choose the administration of stilbamidine in preference to the performance of operation. The good results, the small number of complications, and the routine preservation of the corneal reflex recommend the administration of stilbamidine to patients with tic douloureux.

Medical College of Georgia

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Herpes Zoster Treated with Immune Globulin

VINCENT J. CIRINCIONE, M.D., Savannah, Georgia

THE DRAMATIC RELIEF OF PAIN in patients with herpes zoster treated with Immune Globulin® has recently been reported by Rodarte and Williams.¹ They report on 11 patients treated in such a manner from January 1954 to May 1955. Percentage results were not given, the assumption being that all were helped.

I should like to report on three white adults with herpes zoster. Treated with intramuscular injections of Immune Globulin were two males, aged 46 years and 56 years, and one female aged 57 years. The men had each suffered with herpes zoster 72 hours when the first injection of 20 cc. Immune Globulin was given intramuscularly. Both patients were in severe pain, and both had been told to ignore the early signs and symptoms and return only if they felt they had to. In both cases pain ceased markedly after the third injection, and the patients stated they no longer needed sedation. Both were intensely grateful.

The third case, the woman, had had her herpes

zoster four weeks when the first injection was given. The eruption was involuting, but severe hyperesthesia involving the right intercostal area and pain had persisted. She got no relief whatsoever from five injections of 20 cc. Immune Globulin given daily for five days. When last heard from, two weeks after cessation of treatment, she needed sedation and was still unable to return to her position as a teacher.

While it is obvious that the report of the above three cases does not constitute enough to draw definite conclusions, the dramatic effect of Immune Globulin appears superior to the usually described treatments for pain and neuralgia of herpes zoster. The duration of the disease before treatment with Immune Globulin may be a factor in the response.

800 Abercorn Street

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State Board of Health Meets

HOSPITAL FUNDS, MIDWIFE regulations, and civil defense were considered April 18 by the State Board of Health in its semi-annual meeting.

Fred H. Simonton, chairman, presided as the board heard reports from Thomas F. Sellers, director of the Georgia Department of Public Health.

The board voted the use of up to \$175,000 of Hill-Burton federal hospital construction funds for an equipment project for the laboratory of the proposed new Health Department Building in Atlanta. The board also approved the setting up of one diagnostic and treatment project in Georgia as a demonstration facility.

Rules and regulations for Georgia hospitals were amended to require protection of patients and employees against over-exposure to radiation from radium and other radioactive substances in addition to X-ray radiation as previously required.

The board commended the Georgia Hospital Care Study Commission, Governor Marvin Griffin, and the General Assembly for legislation to establish a program for hospital care of the indigent.

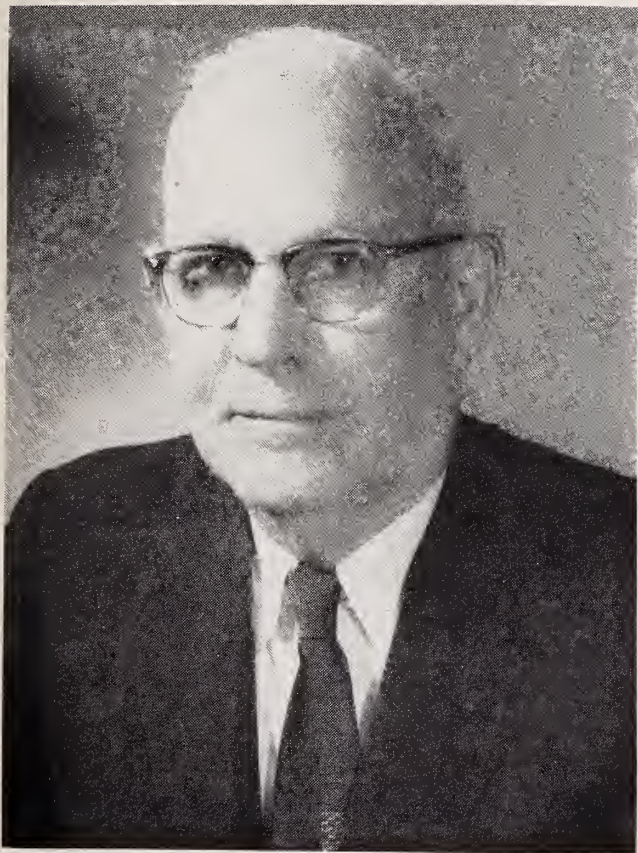
Allotments of state and federal grant funds were withheld from the Fulton-DeKalb Hospital Authority for any type of construction until further study; funds were likewise withheld from the Valdosta-Lowndes County Hospital Authority until a baseball field now directly adjacent to the hospital is removed.

Alterations concerning certificates were made in regulations on the practice of midwifery.

The director of the Department of Public Health had previously been appointed director of the State Civil Defense Service by the Governor. Since the Department of Public Health is in Atlanta, a critical target area, the board of Health voted unanimously to authorize the director to investigate alternate sites for relocating the Health Department in the event the present one should be destroyed, and to establish a line of succession for emergency direction of the Department if the director became incapacitated, until the board could convene and reorganize the Health Department.



Lee Howard of Savannah Is President-Elect



Dr. Howard

ON MAY 1, 1957, Lee Howard, Savannah, was named by the Medical Association of Georgia to serve as president-elect for the year 1957-58. He was installed with the other newly elected officers at the final General Session of the 1957 Annual Session held in Savannah, April 28-May 1, 1957.

Dr. Howard is a graduate of Mercer University, Macon, and Johns Hopkins Medical School, Baltimore. He received his M.D. degree in 1913 and took postgraduate training at Johns Hopkins in the summer of 1916 and of 1917. He was a resident physician at Telfair Hospital, Savannah, from September through January 1917.

During the First World War, Dr. Howard served as first lieutenant in the U. S. Army Medical Corps. He was Chief of Urological Service and Director of the Clinical Laboratory at General Hospital 14, Fort Oglethorpe, Georgia.

Dr. Howard established the first clinical laboratory in South Georgia, at the Telfair Hospital, in

1915. This laboratory has been in continuous operation ever since. Beginning in 1929, he organized and directed clinical laboratories in every Savannah hospital. He was AA Surgeon and Director of Laboratory, U. S. Marine Hospital, No. 20, Savannah, from 1920 through 1950 when his optional retirement was obtained. He was appointed to serve on the First District Advisory Board during World Wars I and II. In 1940, he became Clinical Pathologist to the First District Medical Advisory Board, in charge of the blood program.

In 1945, a partnership was formed with his son, Lee Howard, Jr., Savannah, and Mrs. Catherine T. Miller, M. T., known as the Howard Clinical Laboratory. Another son, Robert M. Howard, is now a partner in the clinic as is H. L. Schofield, Jr., and Mrs. Elizabeth Meyer, M.T.

Dr. Howard is consulting pathologist to Memorial Hospital of Chatham County; Bulloch County Hospital, Statesboro; Emanuel County Hospital, Swainsboro; and pathologist to the Telfair, the Central of Georgia Railway Hospital, Oglethorpe Sanatorium, and the Georgia Infirmary.

He is a member of the Georgia Medical Society (president, 1930-31, trustee, 1931-55, and former secretary-treasurer), First District Medical Society (president, 1934), and has been First District Councilor to the Medical Association of Georgia since 1944. He is fellow of the American College of Physicians, the American Society of Clinical Pathologists, and the American College of Pathologists.

Dr. Howard has been a director of the Savannah Cancer Clinic since 1948; and during 1946 and 1947 he organized the Savannah Tumor Clinic, Inc., which has operated the State Aid Clinic and a therapeutic clinic since that time. He is also a member of the Board of Directors and Vice-Councilor of the Chatham County Unit of the American Cancer Society. He was president of the Chatham-Savannah Health Council from 1945-1946, a charter member of the Kiwanis Club of Savannah, from which he had to resign in 1946 for health reasons, and he belongs to the Men's Garden Club of Savannah.

Dr. Howard has served the Medical Association of Georgia and organized medicine in Georgia well for many years. His elevation signifies that his fellow members recognize his unstinting devotion to the cause of organized medicine and pay tribute, with the highest praise they can give a member, to his devotion, ability, and accomplishments.

MAG Has New Secretary



Dr. McLoughlin

CHRISTOPHER J. MCLOUGHLIN, ATLANTA, has been named by his fellow members of the Medical Association of Georgia to serve as secretary of the Association for the next three years. Dr. McLoughlin succeeds David Henry Poer in this office.

A native of Philadelphia, Pa., Dr. McLoughlin was educated at St. Joseph's Preparatory School and College and Hahneman Medical College, Philadelphia. He interned at St. Mary's Hospital, Philadelphia, and was a fellow in internal medicine at the Mayo Clinic, Rochester, Minn., from 1937 through 1941.

He entered the Medical Corps of the U. S. Army in April 1941 and was stationed at Lawson General Hospital, Atlanta. He was released from active duty in February 1945 with the rank of major.

Immediately after his release from military service, Dr. McLoughlin entered private practice in Atlanta in partnership with the late James Edgar Paullin. The association was continued until Dr. Paullin's death in 1951. He now practices internal medicine in association with William R. Minnich and William L. Paullin, in Atlanta.

The new secretary is a member of the Fulton County Medical Society and the American Diabetes Association; a fellow of the American College of Physicians; a charter member and first president of the Diabetes Association of Atlanta and first presi-

dent of the Georgia Diabetes Association. He is also governor for Georgia of the American Diabetes Association. He has been chairman of the MAG Committee on Public Service for the past three years and was chairman of the Fulton County Medical Society Committee on Public Relations from 1950 through 1954, during which time the medical forums sponsored by the society and the Atlanta Newspapers, Inc., were inaugurated.

Dr. McLoughlin is a member of Sigma Xi, honorary scientific fraternity; Georgia Academy of Science; Phi Chi, medical fraternity; Kiwanis Club of Northside Atlanta; Capital City Club; and Cathedral of Christ the King, Atlanta.

Dr. and Mrs. McLoughlin, the former Miss Jane Sharp of Atlanta, have two sons, Chris, Jr., age 13, and Norman, 8. They live at 417 Hillside Drive, N.W., Atlanta.

Congratulations to the new secretary and to the Association for its good fortune in having so able a man to serve in this important office for the next three years.

Tube Feeding

THE FEEDING OF PATIENTS who will not or can not eat a solid diet by placing a tube of some sort into the stomach has become commonplace in hospital routine. It has been especially useful in the comatose, mentally deranged, chronically ill, and the aged patient. The diets used must of necessity be fluid, and for the most part are highly concentrated (1 or 2 cal/cc.), contain large quantities of protein, and have a relatively high potassium and a low sodium content. Analysis of diets from several Atlanta hospitals showed a range of 2.0 to 3.5 grams for sodium calculated as the chloride salt and a range of 6.2 to 8.7 grams for potassium calculated as the chloride salt. The total volume given is from 2,000 to 2,500 cc. per 24 hours divided into feedings every two or three hours. Although tube feeding may be considered in most instances an innocuous procedure, there are certain complications which may arise of which the physician should be mindful.

Probably the most common complication is diarrhea. This can result from too rapid feedings, too large a volume, too much fat in the diet, or in some cases it may be due to large quantities of vitamins which are sometimes added. Rapid distention of the jejunum also causes abdominal cramps or discomfort.

If the patient is severely dehydrated and depleted of electrolytes, this condition should be corrected by appropriate I. V. fluids before tube feeding is begun. The placing of a concentrated or hypertonic solution into the gastrointestinal tract of such a patient may precipitate circulatory collapse by drawing water

from an already contracted extracellular volume into the stomach and intestines.

Many elderly patients have unrecognized renal damage which may not become evident until the patient is subjected to intubation with the usual low sodium, high potassium diet. Patients with long standing pyelonephritis and some hypertensive individuals frequently cannot conserve salt and require more than the two to three grams often found in the average tube feeding mixture in order to avoid sodium depletion. On the other hand, the occasional patient with far advanced renal disease who is not able to increase his urine volume will not be able to tolerate the large amounts of potassium.

Patients in uremic acidosis may be made worse by a diet with a high protein content. Individuals with normal kidneys who are in the early stages of a stressful situation, or who are experiencing reaction to injury, are in a so-called nitrogen rejection phase, and large amounts of protein are apt to produce a solute diuresis. In these patients, rapid dehydration and in some cases hypernatremia will occur even while the patient is excreting large volumes of urine.

There is no justification for the use of tube feeding as a substitute for good nursing or dietary care. Gastric gavage should never be used as a threat to the patient. The elderly patient adjusts poorly to a sudden change from his familiar surroundings and routine. A kind nurse or the assistance of a member of the family and a selected, attractive and well prepared meal can contribute much more to the well-being of the patient than a tube.

Listed below is a typical diet selected from a representative metropolitan hospital.

Whole Milk Powder	200 grams
Sugar	100 grams
Brewer's Yeast	50 grams
Eggs	2
Evap. Milk	400 cc.
Orange Juice	200 cc.
Water added to make a volume of 2,400 cc.	
This diet contains 2,366 calories (1 cal/cc).	
Carbohydrate 256 grams, Protein 115 grams,	
Fat 98 grams.	
Sodium 3.4 grams (as Sodium Chloride)	
Potassium 8.7 grams (as Potassium Chloride)	

Note: This diet is not given as an ideal diet, but only as an example of the type frequently used for tube feeding.

District Society Meetings

THE TRADITION OF district medical society meetings in Georgia is an old one, and this year they have been held as in years past; all but two of the 10

district societies have convened already in 1957. Assuming that 40 or 50 physicians and their wives gather at each session (and most districts meet in both the fall and spring), it can be seen that attendance averages slightly less than 1,000 annually.

Generally the scientific program is held in the afternoon followed by a social hour and/or barbecue or banquet. Occasionally an after dinner speech is presented, but these are infrequent. This spring Mayor Cheney Griffin of Bainbridge, aide and brother of Governor Marvin Griffin, addressed the Second District Medical Society meeting, and Dean Arthur Richardson of Emory University School of Medicine was the banquet speaker at the First District Medical Society meeting in Statesboro.

The Eighth District meeting, held at the Jekyll Island Hotel near Brunswick, achieved a new high in attendance, with 70 physicians attending to hear two out-of-state speakers and to inspect the new vacation facilities on Jekyll Island. Mr. Tom Hendricks, Field Service Director of the American Medical Association, spoke at both the Seventh and Second District meetings and added considerable prestige to the program.

Nothing can replace the good fellowship and participation of local speakers in the various specialties. The district meetings are above all a chance for the busy physician to find out what his confreres are doing and thinking. Not only can the physician see the familiar faces seen at his county society meetings, but he is also afforded the opportunity of meeting with colleagues from other areas.

There have been isolated comments that these meetings are always run by the same people, thereby limiting the number of physicians who can have a real part in the planning of the meeting and the organization of the society.

This criticism is true to a certain extent, because there is usually a group of faithful men who attend every meeting and who do the work of "local arrangements" and providing entertainment. We know of at least two district societies which would have long since become extinct if it hadn't been for the work of one individual member in each organization who has kept the ball rolling.

In closing, it might also be noted that one of the pleasures of attending district meetings is the anticipation of greeting these faithful-few again. Occasionally, one of them is absent and it is not unusual to hear a number of members saying, "Where's Joe? This is the first district meeting he's missed in years."

Recommendation: If more members would join the thin ranks of the faithful there would be no cause for anyone to say that district societies are run by just a few, always "the same old crew"—let's all attend these fine meetings!



The newly installed President of the MAG — W. Bruce Schoefer, Toccoo.

ANNUAL SESSION



Christopher J. McLoughlin, Atlanto, newly elected MAG Secretary, W. Bruce Schoefer, President 1957-58, T. A. Peterson, Sovonnoh, 1st Vice-President, and Hol M. Dovison, MAG President 1956-57.



A physicion talks to o commercial exhibitor.



Chester Scott Keefer of Boston presents the Abner Wellborn Colhoun Memorial Lecture.

Seven post presidents of the Medical Association of Georgio: W. R. Doncy, Sovonnoh; Hol M. Dovison, Atlanto; W. A. Selmon, Atlanta; Grody N. Coker, Conton; Allen H. Bunce, Atlanto; C. H. Richordson, Macon; ond H. Dawson Allen, Jr., Milledgeville.



HIGHLIGHTS



Drs. Lowance and Letton study Second Place Scientific Award winner — "Hysterosalpingography—Gross Pathology," Henry E. Steadman, Hapeville.

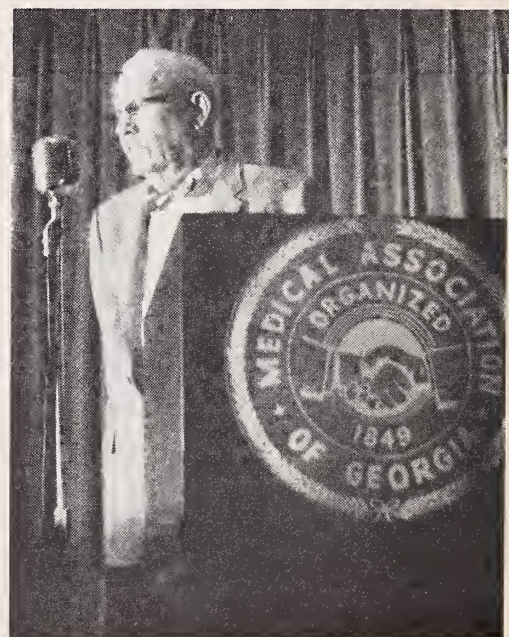


Edgar Baling looks at Third Place Scientific Award — "Rectal Polyp," Leonard J. Rabhan, Savannah.



First Place Scientific Award winning exhibit—"Infertility: Diagnosis and Treatment," Robert B. Greenblatt, Joan Landry, B.A., Edwin Jungck, and William E. Barfield, Augusta.

Lee Haward, Savannah, President-elect for 1957-58.



Dr. Goodwin, Speaker, presides at a meeting of the House of Delegates.



The Importance of the History of the Cardiac

L. MINOR BLACKFORD, M.D., Atlanta, Georgia

PAUL WHITE HAS SAID that if ever it were impossible for him to both take the history and examine a patient, he would take the history and let an associate do the examination. To take a good history one must be first of all a *doctor* as Dr. White is.

Is the "shortness of breath" complained of merely the sighing type of respiration characteristic of psychoneurosis, especially in fat middle-aged women with tight girdles? A stomach full of air may produce discomfort that the kind of patient who swallows air excessively will attribute to her heart. Is it hysterical hyperventilation?

Or is it the real dyspnea of effort? How much effort is necessary to provoke it? Is less effort required now than six months or a year ago? How much physical activity does he engage in? Many people, especially among those over 40, don't enjoy exercise! Would he play golf more if he could?

Does he, between the time he turns off the light and the time he falls asleep, feel his heart "stop for a second," or perhaps "turn over" or suddenly give a single beat that "shakes the whole bed"? How does he sleep? Can he sleep flat? Has he used two pillows for years? "Smothering" at night is a common complaint. What does he mean by the term? Does he mean that he "smothers" when he lies down but is able to sleep soundly once he has fallen asleep? Or, if after several hours of sound sleep he wakes up suddenly, what does he do? Does he merely roll over and go back to sleep, or perhaps get up and empty his bladder for lack of something better to do before falling asleep again promptly? Or does he have to sit up straight to catch his breath, perhaps even rush to an open window?

Swineford has distinguished two kinds of "cardiac asthma": in one the patient awakes with a start, his chest full of moist rales but no sonorous ones; in the other, wheezes obscure moisture. Both types need dehydration, but the second needs also a

plastic pillow case.

Does his heart sometimes abruptly begin to race and then quiet down with equal suddenness? Or is he unaware when his heart began to beat rapidly, and does it slow down gradually? Has he ever noticed any swelling around the ankles? When? Was there any swelling around the eyes? Does his occupation keep him on his feet relatively motionless all day? Is the swelling only present in hot weather? When was the last time his urine was checked?

Does he have chest *pain*? Where is it? Pain over the apex is almost always *not* associated with the heart. Does it radiate? What brings it on? For how long has he had this pain? Is the pain provoked by less exertion or excitement than formerly? Is it accompanied by dyspnea? Has he ever suffered agonizing chest pains for hours, accompanied by drenching sweats and perhaps restlessness?

Has he ever had rheumatic fever? It is well to use synonyms, ask about nosebleeds, repeated sore throats, and other relevant symptoms. Has he ever had syphilis? Has he ever taken "shots" for some length of time? Is there a family tendency to high blood pressure, strokes or sudden death? Has his own blood pressure ever been found high? When was it last taken?

How is his digestion? Does he ever vomit? Has he ever passed tarry stools? Suffered from bleeding piles? If a woman, does she menstruate excessively?

Has he lost weight? Is he very emotional? Has he always been a worrier or did he just a few months ago for the first time in his life become very nervous, with tremor and excessive appetite, weakness and diarrhea?

These questions are, of course, not all that should be asked. In the individual case, the doctor may find clues to lead him on to many more. But by the time the history is completed, if the doctor has not arrived at a tentative diagnosis he should at least know what sort of a person he is dealing with.

Prepared at the request of the Committee on Professional Education of the
Georgia Heart Association

Lay Evidence of Medical Negligence

JOHN A. DUNAWAY, Atlanta, Ga., Legal Counsel for the Medical Association of Georgia

IN THE FEBRUARY issue of the *Journal of the Medical Association of Georgia*, I commented upon the decision of the Court of Appeals rendered on November 29, 1956, in the case of Phillips v. Shea, in which it was held that the trial judge committed error in granting a non-suit in a suit against a physician based on lay evidence when there was no medical evidence to support the charge that there had been an improper performance of an operation and negligence in performing a second operation without consulting with another surgeon.

The attorney representing the physician filed a motion for a rehearing and the Court of Appeals denied the motion. In regular course, application was made to the Supreme Court for a writ of certiorari to review the decision of the Court of Appeals. This application was granted and on March 11, 1957, oral arguments were had before the Supreme Court on the questions raised by the petition for certiorari; namely, that in several particulars a jury would be permitted to say whether or not certain medical acts performed by Dr. Shea were or were not negligence on his part as a physician, when there was only lay evidence to support the charge.

About this time, the undersigned was requested by the officials of the Medical Association of Georgia to file a brief amicus curiae with the Supreme Court in support of Dr. Shea's petition for certiorari.

Local societies about the state employed counsel likewise who filed briefs amicus curiae in support of Dr. Shea's position. Briefs were filed by the law firms of Cumming, Nixon and Eve in Augusta, on behalf of the Richmond County Medical Society; Eberhardt, Franklin, Barham and Coleman, in Valdosta, on behalf of the South Georgia Medical Society; Nightingale and Liles of Brunswick, on behalf of the Glynn County Medical Society; Anderson, Anderson, Walker and Reichert, on behalf of the Bibb County Medical Society; and Alexander, Vann and Lilly at Thomasville, on behalf of Thomas-Brooks Medical Society.

I am glad to report that the Supreme Court has granted a reversal of the Court of Appeals in this case with a clear cut ruling that before a physician

or surgeon may be held to be negligent in the trial of a law suit in this state, there must be competent expert medical evidence by which to establish his negligence. In rendering its decision in this case the Court said:

"We have carefully examined all of the evidence; and after doing so, are fully convinced that it shows no fact or circumstance from which the jury could have found or inferred that Dr. Shea was negligent in the respects mentioned by the Court of Appeals in its decision."

As far as Dr. Shea is concerned this decision was a clear vindication of his original victory in the lower court.

Upon a review of the evidence the Supreme Court stated,

"It clearly shows that Dr. Shea, in performing the two operations, exercised that degree of care, skill, and diligence which any competent surgeon would be required to employ in doing, as here, intricate and dangerous operations. . . . This court will not hold that a jury is authorized to find that a competent surgeon is negligent in performing an operation until he calls some other surgeon to assist him."

In affirming the true rule that laymen could not judge the acts of physicians the court said:

"More than 2,300 years ago Aristotle, in his work, *Politics*, wrote: 'As the physician ought to be judged by the physician, so ought men to be judged by their peers.' And for centuries the courts of this and other countries have, almost without exception, held that expert medical evidence is required to establish negligence respecting the services a physician or a surgeon renders his patient."

It is the judgement of your writer that this decision is a very vital landmark in the law of this state in determining the responsibility of a physician in a claim for damages growing out of charges of negligence in the treatment of a patient.

The Court did not indicate that it would vary the rule stated in *Pilgrim v. Landham*, 63 Ga. App., thusly,

Official Opinions of the Judicial Council

(As given in the J.A.M.A., March 30, 1957)

Question: How does the Judicial Council define "clinic"?

Answer: The Judicial Council has stated before that it does not define terms that may connote ethical or unethical conduct. Nor does it believe it to be within its province to attempt to approve or disapprove, encourage or discourage particular forms of medical practice by definition. The Principles of Medical Ethics are themselves the criteria by which the ethical nature of professional conduct is determined. In connection with any definition of the word "clinic", it should be clear that regardless of how clinic is defined, each physician-member of the clinic must act, in his relations with his patients and his colleagues, in accord with all the Principles of Medical Ethics. No physician-member of any clinic may permit the clinic to do that which he may not do. Each physician must observe all the Principles of Medical Ethics.

Under the ethical principles of medicine no use may properly be made of the word clinic that would mislead or deceive the public, or would tend to be a solicitation of patients to the particular group of physicians holding themselves out as a "clinic".

Question: Is it ethical for a physician to indicate on his letter or billhead, or his professional cards, that he is a member of fellow or diplomate of some specialty organization within the medical profession?

Answer: The physician should limit the use of statements of qualifications and honors on letter and bill-heads and professional cards to the simple, dignified abbreviation, "M.D.", or the statement "Doctor of Medicine". To do more smacks of self-lauda-

tion, borders on solicitation of patients, and tends to reduce the degree and title "Doctor of Medicine" to secondary importance. While it cannot be concluded that it is unethical to use specialty designations in this manner, it can be said that the practice is not in the best of taste or in the best interest of the profession.

Question: What is unethical advertising?

Answer: The Principles of Medical Ethics do not proscribe advertising as such: they proscribe the solicitation of patients. Advertising, in its broad sense, means the act of making information, fact, or intention known to the public. Solicitation, as used in the Principles, means the attempt to obtain patients by persuasion or influence. Advertising, as distinguished from solicitation, is not in itself unethical.

The public is entitled to know the names of physicians, the types of their practices, the locations of their offices, their office hours, and the like. The doctor may ethically furnish this information through the accepted local mediums of advertising, which are open to all physicians on like conditions. Telephone listings, office signs, professional cards, dignified announcements, all are acceptable mediums of making factual information available to the public.

The particular use to be made of any ethical advertising medium and the extent of that use are, however, matters to be determined according to local ideals. What constitutes an excess, what is not in keeping with the ideals of medicine, what transcends advertising and becomes solicitation are questions of fact. The application of this principle is to be made locally.

Legal Counsel Page (cont'd.)

"What is the proper method of diagnosing a case is a medical question to be testified to by physicians as expert witnesses. Laymen, even jurors and courts, are not permitted to say what is the proper method of diagnosing a case for discovering the nature of an ailment. *Result of the diagnosis and treatment, if so pronounced as to become apparent, as where a leg or limb which has been broken is shorter than the other after diagnosis and treatment, may be testified to by anyone. . . . And, where, measured by the method shown by medical witnesses to be negligence and*

the evidence, a bad result is shown, it is the province of the jury to say whether the result was caused by the negligence (italics author's)."

But we think the decision of the Supreme Court in Dr. Shea's case is a very clear indication that our trial judges will be governed strictly by this rule in its application to evidence submitted, and, unless there is in fact expert testimony which would measure the standard of the physician on trial, a jury will not be permitted to say whether or not the standard has been violated.

Grant Building



physician's bookshelf

Books Received

Arey, Leslie Brainerd, Ph.D., Sc.D., LL.D.; William Burrows, Ph.D.; J. P. Greenhill, M.D.; and Richard M. Hewitt, A.M., M.D.; **DORLAND'S ILLUSTRATED MEDICAL DICTIONARY**, 23rd Edition, W. B. Saunders Company, Philadelphia, 1957, 700 ill., 50 plates, \$12.50.

Campbell, Meredith F., M.D., **PRINCIPLES OF UROLOGY**, W. B. Saunders Company, Philadelphia, 1957, 622 pp., 319 figs., \$9.50.

Dunn, Holbert L., M.D., Ph.D., **YOUR WORLD AND MINE**, Exposition Press, New York, 1956, 94 pp., \$3.00.

Eastman, Nicholson J., M.D., **EXPECTANT MOTHERHOOD**, Little Brown and Company, Inc., Boston, 1957, 194 pp., \$1.75.

Exner, F. B., M.D.; G. L. Waldbott, M.D.; and Hames Rorty (Editor), **THE AMERICAN FLUORIDATION EXPERIMENT**, Devin-Adair Company, New York, 1957, 264 pp., \$3.75.

Hart, Hornell, Ph.D., Duke University, **AUTOCONDITIONING: THE NEW WAY TO A SUCCESSFUL LIFE**, Prentice-Hall, Inc., Englewood Cliffs, N. J., 1956, 255 pp., \$4.95.

Krieghbaum, Hillier, **WHEN DOCTORS MEET REPORTERS**, Josiah Macy, Jr., Foundation, New York University Press, New York, 1957, 119 pp.

McNeill, Donald R., **THE FIGHT FOR FLUORIDATION**, Oxford University Press, New York, 1957, 236 pp., \$5.00.

Netter, Frank H., M.D., **LIVER, BILIARY TRACT AND PANCREAS**, Part III, Volume 3, Digestive System, The Ciba Collection of Medical Illustrations, Ciba Pharmaceutical Products, Inc., Summit, N. J., 149 pp., \$10.50.

Sargent, William, M.D., **BATTLE FOR THE MIND**, Doubleday and Company, Inc., Garden City, N. Y., 1957, 239 pp., \$4.50.

Smith, Donald R., **GENERAL UROLOGY**, Lange Medical Publications, Los Altos, Calif., 1957, 328 pp.

Thigpen, Corbett H., M.D., and Hervey M. Cleckley, M.D., **THE THREE FACES OF EVE**, McGraw-Hill Book Company, Inc., New York, 1957, 308 pp., \$4.50.

Tracy, John Evarts, **THE DOCTOR AS A WITNESS**, W. B. Saunders Company, Philadelphia, 1957, 221 pp., \$4.25.

Winton, F. R. (Editor), **MODERN VIEWS ON THE SECRETION OF URINE**, Little, Brown and Company, Boston, 1956, 273 pp., \$8.50.

Zimmerman, Leo M., and Rachmiel Levine, **PSYCHOLOGIC PRINCIPLES OF SURGERY**, W. B. Saunders Company, Philadelphia, 1957, 988 pp., \$15.00.

Council on Pharmacy and Chemistry, **NEW AND NONOFFICIAL REMEDIES 1957**, J. B. Lippincott Company, Philadelphia, 1957, 570 pp., \$3.35.

Reviews

Lippman, Hyman S., M.D., **TREATMENT OF THE CHILD IN EMOTIONAL CONFLICT**, McGraw-Hill Book Company, Inc., New York, 1956, 298 pp., \$6.00.

This volume is a welcome addition to the physician's bookshelf. It is based on Dr. Lippman's experience of 25 years in the Amherst H. Wilder Child Guidance Clinic in St. Paul, Minnesota. His clear delineation of clinical syndromes has an orderliness which is satisfying to the man in practice. This makes it an important aid in studying a particular child and in advising the parents on a plan of treatment. All workers dealing with troubled children will find it of value, and the section on prevention is of special interest to those concerned with community organization for mental health.

The general methods of treatment are based on psychoanalytic principles with modifications ironed out by the staff of the Wilder Clinic. These methods are discussed in general and are illustrated by excerpts from many cases.

The first section "Approaching Therapy" outlines the

technics of therapy and the steps by which the child and his parents begin to take part in their work with the clinic.

There are sections covering four major clinical groups. These are: neurotic illness, personality problems, delinquency, and the child with a tenuous hold on reality. In this latter group are included psychosis, unstable child, organic brain damage, and seizures. The presentation by clinical groups makes for clearer exposition of the psychopathology and methods of treatment.

Following the various children who inhabit this book in their experiences in the clinic gives the reader some familiarity with the workings of a child guidance clinic. The case histories are given in clear language in terms of what children do and feel and think. This avoids the "private language" of psychoanalysis and makes the book understandable to the interested reader. "The Therapist" so often mentioned but always anonymous gradually becomes a real person, and in his relationship with Alan, Ruth, or Doris (never "the patient") things begin to change.

"Why are the children so disturbed that their future adjustment will be jeopardized unless they can obtain therapy?" This important question is answered with definite recommendations.

There is an excellent chapter on prevention with recommendations which are too important not to be touched upon in this review. The staff of a child guidance clinic lives intimately with social and emotional maladjustment and is in a position to recognize the origins of mental illness and the effects of treatment. The clinic also works closely with many social agencies, schools, and institutions. Through years of their cooperative activity, workable methods have developed for assisting certain families. Dr. Lippman's plan is to extend these methods to the entire community so that full use may be made of procedures known to be effective.

Early recognition of family disorganization and early recognition of emotional problems in children is the first step. This can be done by hospitals, clinics, schools, social and welfare agencies, etc. To provide services for these people is the next step—services to strengthen the weak family and improve and expand services for children.

The outlines can only be sketched here. The details of each service are persuasively discussed in the text.

W. H. Kiser, Jr., M.D.

Gorman, Mike, **EVERY OTHER BED**, World Publishing Company, Cleveland and New York, 1956, 309 pages.

Every other hospital bed in the United States is occupied by a mental case, and the Executive Director of the National Mental Health Committee sets out in this volume to explain why and recommend a plan for the future.

It is a report in a sense on the status of mental illness in the United States and is good reporting and interesting reading.

Primarily a book written for lay readers but will be of interest to anyone concerned with mental health.

Sections of Neurology and Section of Physiology, Mayo Clinic and Mayo Foundation, **CLINICAL EXAMINATIONS IN NEUROLOGY**, W. B. Saunders Company, Philadelphia, 1956, 370 pages, 76 figs., \$7.50.

Efficiency and a minimum of wasted effort is the key-stone in the conduct of patient evaluation at the Mayo Clinic. There is very often duplication in history taking and particularly in the examination of patients in this environment. Necessarily, this occurs because of the meshing of postgraduate education into a program of medical care and treatment. However, to accomplish both these goals in a huge place, a certain amount of streamlining is essential. There is the old school of neurologists, who are extremely astute in their interpretation of neurologic disorders, and I fear many times have an overwhelming pride in the intricacies of neuro-anatomy and the maze of neurologic diseases. With the modern techniques and newer definitive diagnostic procedures, some of the mysteries have been eliminated which I am certain will be decried by some of the oldsters, perhaps rightfully so. There is still nothing which can supplant a vast experience supported by lightning-like intuitive diagnostic acumen. This older attitude should still be nourished, because the neurologic section of Mayo Clinic is based on a tradition fostered by the patient, diligent, and painstaking putting together of a neurologic jigsaw into a complete neurologic syndrome.

This volume is not a neurologic textbook and is not intended to be. One cannot use it as a reference to diagnose some bizarre disorder of the central nervous system. There are no lengthy studies in neuro-anatomy but only those needed to analyze the function of the body innervated by the sensory or motor outlets.

The section on muscle study is adequate and not overburdened by unnecessary details. Further elaboration of the chapter on the motor and sensory aspects of speech would prove valuable. Criticism could be directed toward the detailed analysis of electromyography with a considerably lesser degree of emphasis on electroencephalography. However, the former is a newer subject and may need additional treatment for this reason rather than because of its practical application, although the criticism is otherwise entirely justified. The chapter on cerebro-spinal fluid studies and examination could be considerably expanded.

On the whole, to familiarize oneself with an efficient routine of neurologic examination, this book will prove exceedingly helpful, but it will not supplant, and I am sure the authors did not intend it to do so, a well grounded knowledge of neurology and neuro-anatomy which can only be obtained by patient study and years of experience.

Robert F. Mabon, M.D.

Wolstenholme, G. E. W., and Miller, Elaine C. P., **PAPER ELECTROPHORESIS**, Ciba Foundation Symposium, Little, Brown and Company, Boston, 1956, 224 pages, \$6.75.

This book on paper electrophoresis publishes the papers and discussions of 22 investigators brought together for a Ciba Foundation Symposium in London, July 1955. The techniques and apparatus are emphasized, thus making available a remarkable collection of experience, problems, and impressions from various countries. It is seldom that such an accumulation of information on any given subject is brought together for ready reference. The list of collaborators includes such

familiar names as: G. H. Beaven, E. M. Crook, E. L. Durrum, W. Grassmann, E. Koiw, H. Laurell, M. Lederer, N. H. Martin, H. Svensson, and J. C. White.

Reagents, particularly dyes and buffers, are discussed in detail. The concept that all dyes are mixtures and can vary greatly in property with various solvents is brought out in the discussions. Dr. Martin includes his experience with bromophenol blue and bromocresol dyes and recommends them as dyes of choice. The advantages and disadvantages of using barbital, borate, phosphate, and acetate buffers are presented, and it is pointed out that the choice of buffer often is determined by the type of protein complex being studied.

Suggestions on how to improve one's technique are found throughout the book. Use of 5 to 15% ethylene glycol in the buffer used to saturate the paper strips will decrease distillation of water from the strip. Helium or hydrogen added to air above the strips in the apparatus will aid diffusion of heat from the strips. Room temperatures near 18°C appear most suitable for runs. Whatman No. 1 paper adsorbs less staining material and permits easier decolorization of paper background. Control of evaporation and water content of paper are considered extremely important.

Several highly controversial subjects, such as the following, are introduced. Should one use constant voltage or constant current? How should mobilities be calculated? What is the best indicator of, and what influences electro-osmosis? Is the hanging strip design of apparatus better than the horizontal type? Although opinions are expressed on these subjects, no common agreement is reached.

Comments on methods of preservation of protein and buffer solutions indicate that sterile technique, merthiolate and copper sulfate are satisfactory means.

The dangerous but potentially highly useful high voltage electrophoresis, which offers greatest utility in analysis of amino acids, peptides, and carbohydrates, is discussed by Dr. Grassmann and by Dr. Kickhofen.

In the field of carbohydrate and lipid complexes and proteins, two excellent papers are presented. Dr. Laurell gives in detail an adaptation of the McManus technique to filter paper electrophoresis for staining polysaccharides. Carbohydrate proteins are found to vary considerably in diseases such as rheumatoid arthritis, and will change in content probably secondary to variations in disease activity. Dr. McDonald describes both an effective procedure of staining lipids, using acetylated Sudan black B, and a new technique of pre-staining lipids in the test tube before electrophoresis.

Particularly interesting is the discussion by Dr. Grassmann of early work and a presentation of the rare abnormality of a patient possessing a complete lack of serum albumin (previously published by Bennhold in *Ber. Ges. Physiol.* 172, 165, 1955). Dr. de Wael reports that he has found paper electrophoresis to be quite useful in differential diagnosis of canine hepatitis, cirrhosis, and tumors. Findings are quite similar to those that have been noted in humans.

This book is highly recommended for persons who wish access to good discussions on apparatus, techniques, limitations, and errors of paper electrophoresis. It is good reading for individuals planning to set up paper electrophoretic apparatus, or for those who are already using this equipment.

Gerald R. Cooper, Ph.D., M.D.



abstracts by georgia authors

Corpe, Raymond F., and Ingrid Stergus, *Batley State Hospital, Rome, Ga.* "Open Healing of Tuberculous Cavities"; *Am. Rev. Tuberc.* 75:223-241 (Feb) 1957.

In this study we define open healed or healing cavities as roentgenographically thin walled, air-containing spaces, solitary or in systems replacing parenchyma, presenting on gross pathological examination either a complete, smooth, glistening, continuous greyish lavender inner lining or — in the healing cases — a break of this continuity with rare millet seed tubercles or scant tuberculous granulation tissue in occasional crypts (the healing cases being a transitional link between the "dirty" tuberculous cavity and the completely healed one).

This phenomenon has been recently discussed in literature under different terminology.

In 487 consecutive pulmonary resections at Batley State Hospital during 46 months, 30 such cases (six per cent) were encountered: 15 totally healed and 15 healing, all proven by detailed bacteriological and pathological (gross and microscopic) work-up.

Such cavities were observed only in cases having had prolonged drug therapy, particularly Isoniazid (only one of these cases had been under streptomycin treatment alone). They occurred three times as frequently in the Negro population as in the white.

A study is now being conducted in which patients with cavitation (often bilateral), who are not surgical candidates but have had long-term negative sputum, are being discharged on drug therapy with careful community follow-up.

Kethley, T. W.; E. L. Fincher; and W. B. Cown, *Engineering Experiment Station, Georgia Institute of Technology, Atlanta, Ga.* "The Effect of Sampling Method Upon the Apparent Response of Airborne Bacteria to Temperature and Relative Humidity"; *J. Infect. Dis.* 100:97-102 (Jan-Feb) 1957.

Results are reported for the death rates (k) of airborne *Serratia marcescens* (ATCC274) under varying conditions of humidity at temperatures between —40 and 32 C, as determined from studies employing (1) agar settling plates held at the temperatures of the aerial sample, (2) critical orifice liquid impingers held at the temperature of the aerial sample, and (3) critical orifice liquid impingers held at 20-27 C. These results indicate that erroneously high values for the death rate are obtained when agar plates are employed at temperatures above 24 C or below 18 C, or liquid impingers held at temperatures below 15 C. The data from liquid impingers held at 20-27 C indicate a positive correlation between temperature and death rate, although for different temperatures relative hu-

midity has a differing effect upon the death rate. It is suggested that this information is of value in indicating the relative potential of airborne bacteria in spreading diseases under various atmospheric conditions.

McInnes, George F. and Harold S. Engler, *Medical College of Georgia, Augusta, Ga.* "Experiences with the Ileal Bladder in Radical Pelvic Surgery," *Cancer* 9:1219-1226 (Nov.-Dec.) 1956.

Radical pelvic surgery for advanced cancer that involves removal of the bladder and distal portions of the ureters leads one to the consideration of the reconstruction of the urinary tract. Various techniques have been devised and used successfully, one of which is the use of an isolated ileal segment into which the divided ureters are transplanted.

The authors report on their experiences using this method of urinary tract diversion in 19 cases. The operative technique is carefully described and illustrated.

The ileal bladders were constructed in cases of total pelvic exenteration for carcinoma of the cervix (5) or fundus (1), in anterior pelvic exenteration for carcinoma of the cervix (7) or bladder (1), and palliation for obstruction of the ureters (5) in cases of recurrent carcinoma or stenosis following previous procedures.

Preoperative and postoperative excretory urograms of representative cases are presented. Electrolyte studies were done and no case of hyperchloremic acidosis was found.

The conclusion was that construction of an ileal bladder is a satisfactory method for urinary tract diversion as evaluated by (1) pre- and postoperative excretory urograms; (2) pre- and postoperative electrolyte studies; (3) a minimum of serious postoperative complications; (4) ease of management of external urinary receptacle; and (5) no evidence of severe immediate postoperative or delayed urinary infection.

Fair, John R., *Dept. of Surgery, Medical College of Georgia, Augusta, Ga.* "Eye Armor"; *Am. J. Ophthalm.* 43:258-264 (Feb) 1957.

The increased use of the fragmentation type of explosive weapon seen in World War II and the Korean conflict caused an increase in wounds of the eye in combat troops. The recognition that most such wounds were produced by very small shell fragments that had force enough to penetrate only the lids and the coats of the eye suggests the use of the ordinary safety goggle that has proved so effective in protecting the eyes of industrial workers. The particular device that is recommended is the spectacle-type goggle with tempered glass lenses and side shields. It is believed that eye armor of this kind

would greatly reduce the number of ocular injuries in combat soldiers. The only real problems foreseen are making the goggles acceptable to the soldier who has never before worn spectacles and providing corrective lenses for the soldier with a significant refractive error.

Gay, Brit B., Jr., and Sam Wilkins, Jr., *Emory University Hospital, Emory University, Ga.* "The Fluoroscope with Image Amplifier in the Study of the Larynx and Pharynx," *Cancer* 9:1253-60 (Nov-Dec) 1956.

The use of the image amplifier for the fluoroscopic evaluation of the larynx and pharynx is discussed. The routine of examination is described, and eight cases are presented to illustrate various types of lesions which can be identified radiologically in the larynx and pharynx. These include vocal cord paralysis, carcinoma of the vocal cords, carcinoma of the epiglottis, carcinoma of the tongue, carcinoma arising in the aryepiglottic fold, carcinoma arising in the pyriform sinuses.

In summary the following conclusions seem justified: (1) roentgenological examination should be used routinely in all patients exhibiting tumors of the upper air and food passages, (2) fluoroscopy with the image amplifier is a valuable adjunct to radiological study of the laryngopharynx, (3) by careful correlation of roentgenological and clinical findings, laryngo-pharyngeal tumors may be more accurately staged and localized as to site of origin and extent, (4) roentgenological study is valuable in following the response of laryngo-pharyngeal tumors to roentgen ray therapy and in postoperative follow-up after hemilaryngectomy of cordectomy, and (5) vocal cord paralysis and fixation are readily observed with the fluoroscopic image amplifier.

Rice, Guy V. Jr., *Georgia Dept. of Public Health, Atlanta, Ga.* "The Role of Public Health Nurse in the Hospitalization of Mental Patients and Their Follow-up After Discharge," *Am. J. Pub. Health* 47:210-214 (Feb.) 1957.

In January 1953 a pilot program to enable public health nurses to offer supportive services to the families of mentally ill patients was begun in Georgia.

After evaluation and consultation with the superintendent and staff of the State Hospital, the State Health Department approved the expansion of the service state-wide. Now, nursing services to families of the mentally ill are becoming an integral part of the public health nurse's responsibility as rapidly as supervision can be provided to local health departments.

The program:

Supports the family in a time of crisis.

Helps prevent isolation of the mentally ill patient and his family from the community.

Aids communication since the local health agency provides liaison between the hospital, the patient and the family.

Uncovers local resources and refers patients to them.

Through this project Georgia has shown one way that public health may meet a part of its responsibility in mental health. This has been rewarding to the families, the public health nurse, and the staff of the State Hospital.

Schwartz, Solomon, Forest Hills Division, VA Hospital, Augusta, Ga. "The Tuberculin Reaction During Chemotherapy for Pulmonary Tuberculosis"; *Dis. of Chest* 31:286-298 (Mar) 1957.

Forty-nine adult males were tuberculin tested at intervals during chemotherapy for pulmonary tuberculosis up to one year of treatment. Patients were predominantly cavity cases with far advanced and moderately advanced disease. A significant increase in size of reaction was present at one to two months of testing. This increase occurred predominantly in Negro patients, those under 50 years of age, in the far advanced group of patients, and it coincided with the period of resolution of the disease process.

To a certain extent this increase in reaction was due to the presence of nine hypoergic cases who showed marked increases in reaction after starting treatment. When this group of patients is excluded, a depression in tuberculin reaction appeared at the 8th and 12th month treatment. This depression was not present in patients who did not convert their sputum. No significant difference in response of the tuberculin reaction under chemotherapy could be determined between different chemotherapy regimens. The significant increase at one to two month levels was present in both SM and PAS treated patients. Since both these drugs were used in combination with INH as well as with each other, it is possible that the INH patients would also show similar significant changes if a larger group of patients were used.

Steadman, Henry E., 3021 Stewart Ave., Hapeville, Ga. "Ovarian Cyst Following Supracervical Hysterectomy," *J. Internat. Coll. Surgeons* 27:170-175 (Feb) 1957.

A case of post-hysterectomy ovarian cyst is presented. Material for study and determination of preoperative diagnosis is obtained by transvaginal aspiration. The empty cavity is filled with a contrast medium (ethiodol), and roentgenograms are taken. The bladder is filled with skiodan, and roentgenograms are taken to show the relation of the cyst to the urinary bladder. This has some practical value but may carry more academic interest.

The possible complications of transvaginal aspiration are discussed, and the advantages of preoperative colpotomy and roentgen study of the cyst cavity are pointed out. The preinflammatory cystic mass is compared with the inflammatory tumor mass, extirpated, and sent to the pathologist.

Skobba, Joseph S., 490 Peachtree St., N.E., Atlanta 8, Ga., "Military Psychiatry" *Am. J. Psychiat.* 113:647-648 (Jan) 1957.

Review of psychiatric progress in Military Psychiatry during 1956 reveals further efforts in adaptation of psychiatric principles to the military setting. Basic training as a screening device was found to be poor in detecting potential inadequacy.

Screening by psychiatrists was highly accurate in selection of subjects for satisfactory service but prediction of unsatisfactory duty was usually erroneous. Psychiatric evaluation of pilots on the spot by a psychiatrist in collaboration with the flight surgeon gave the best opinion available on combat proficiency of a given pilot. Potential discharges of enuretics was reduced 60% by relieving anxiety associated with the condition. A tour of duty in Korea was found not to affect the overall personality characteristics of the soldiers except for some suggestion of an increase in the soldier's aggressive impulses and a decrease in affiliation needs as the tour progressed.

To conserve services of highly trained individuals with long experience whose effectiveness was impaired by an inability to control drinking, a program of promotion restriction and assignment based on personality needs of the individual was recommended.

A new approach to the problem of chronic alcoholism in the military service, consisting of education for prevention, early recognition and treatment of selected individuals, resulted in rehabilitation of one-half the group studied.

In one hospital a program of acculturation of new patients by the patients on the ward with the help and encouragement of the staff eliminated the use of quiet rooms and parenteral sedation.

Carpenter, Frederick A., and William H. Galvin, Emory University, Ga. "Concerning Some Physiologic Responses to a Succinylcholine Chloride Antagonist"; *South M. J.* 50:322-331 (March) 1957.

In answer to a questionnaire sent to 86 major medical centers, it was determined that an antagonist to succinylcholine chloride would be valuable in selected cases of prolonged apnea.

It was suspected that N-Benzhydryl-N-Methylethyl-piperazinium chloride (BW51-212) might be an antagonist of some value.

This study included the responses of 30 dogs and a few clinical trials.

At first, the responses looked promising, but as more experiments were done the responses were found to be variable. There appeared to be no dose ratio of BW51-212 that would regularly antagonize succinylcholine. At times the antagonism was perfect. In other dogs, there was alarming potentiation of the muscle relaxant.

In one series of dogs, definite ganglionic blocking activity was shown to occur after large doses of BW51-212.

Side effects were absent until large doses of BW51-212 were reached.

The paper includes two graphs showing the extreme (96 to 100 per cent)

antagonism of BW51-212 to succinylcholine chloride. However, one graph also shows that as increasing dose ratios are given, antagonism decreases and is finally potentiating at high doses.

In a few selected cases, BW51-212 failed to antagonize succinylcholine in human beings, but caused rapid cycloplegia whether given intravenously or instilled locally into the eye.

It was felt that although BW51-212 was too variable in action, a suitable antagonist to succinylcholine would be valuable.

Merrill, Arthur J., 35 4th St., N.E., Atlanta, Ga. "Nephrotic Syndrome," *Am. Heart J.* 53:305-19 (Feb) 1957.

Evidence is exhibited that most cases of lipoid "nephrosis" may be secondary to acute glomerulonephritis.

New experimental proof is presented that the increase in serum lipids and cholesterol is a result of decreased serum proteins and it is inversely proportional to them.

Serum proteins can be maintained at a normal level if protein intake equals body requirements and urinary losses.

The three year mortality rate in nephrosis without a planned program of steroid therapy is 30 per cent, four year rate, 40 per cent.

Planned steroid therapy may reduce the four year mortality rate considerably, in series without renal failure to zero to five per cent. Treatment does not cure the disease but seems to prevent renal failure until nature effects a spontaneous cure.

Fowler, Noble O.; Edgar P. Mannix, Jr., and William Noble, Dept. of Medicine, Emory University, Ga. "Difficulties in Interpretation of Right Heart Catheterization Data"; *Am. Heart J.* 53:343-358 (March) 1957.

By means of case reports, several difficulties in interpretation of right heart catheterization data are described.

1. A positive pressure gradient in diastole between right atrium and ventricle was found in the absence of tricuspid stenosis.

2. Diastolic pressure in the right ventricle exceeded one-third of the systolic pressure in the absence of constrictive pericarditis.

3. Positive systolic pressure gradients between right ventricle and pulmonary artery were found in the absence of pulmonary stenosis.

4. Causes of increase in oxygenation of right atrial blood other than atrial septal defects are considered.

5. Causes of increase in oxygenation of pulmonary arterial blood other than patent ductus arteriosus are listed.

6. Persistence of patent ductus arteriosus may be associated with increase in oxygenation of right ventricular blood.

7. Difficulty in distinguishing between anomalous pulmonary venous drainage and atrial septal defect is exemplified.

8. Artifactual pressure curves resulting from wedging the catheter tip in the coronary sinus or from motion of the catheter tip in the right atrium are described.

Mental Health Committee

THE SECOND MEETING of the 1956-57 Committee on Mental Health of the Medical Association of Georgia was held at the Biltmore Hotel, Atlanta, Sunday, February 17, 1957.

Members present were: Rives Chalmers, Atlanta, *Chairman*; T. J. Vansant, Jr., Marietta; W. M. Moncrief, Atlanta; Richard F. Felder, Atlanta; Guy V. Rice, Atlanta; Thomas G. Peacock, Milledgeville; and Mr. John F. Kiser of the MAG Headquarters Office.

Report on the AMA Meeting—Dr. Chalmers reported on the meeting of committee chairmen of state medical societies at AMA headquarters in Chicago in November. The topics discussed at the meeting were: (1) the use of hypnosis in medical practice; (2) the alcoholic patient as a medical hospital management problem; (3) benefits and problems encountered by a general practitioner with the use of new tranquilizing drugs for patients with emotional illness; and (4) in-patient psychiatric care for children.

Dr. Chalmers pointed out that the problem of including basic mental health education in training programs for professional people was also discussed. He stated that a number of these topics should be of interest to the Woman's Auxiliary.

Report on Commitment Booklet—In the absence of Dr. Knight, Dr. Felder discussed the plans for the final preparation of the booklet on Georgia's Commitment laws. Dr. Felder pointed out that there would be three sections to the booklet and that all sections would be mailed to the seven sub-committee members for final approval before publication. He stated that the booklet would be ready for the Annual Session of the Medical Association of Georgia, April 28 - May 1. Mr. Kiser was authorized to contact the Georgia Bar Association, the Ordinaries' Association, and the Mental Health Association to determine how many copies of the booklet these groups might want to have.

Report of Subcommittee Headed by T. J. Vansant—The subcommittee on integration and production of an educational movie met February 10, 1957, in the office of Dr. Peacock at the State Hospital in Milledgeville. Those present were: Thomas G. Peacock, H. Dawson Allen, Jr., Guy V. Rice, and T. J. Vansant. The two general topics of discussion were integration of the psychiatric patient's institutional care and rehabilitation with his return to his community and, secondly, the proposed production of an educational movie.

I. Topics discussed in connection with integration were as follows:

A. Obligation of the hospital to the patient's family and his family physician.

1. Proposal of a letter following a patient's admission to be forwarded by the hospital to the patient's family physician outlining diagnosis, prognosis, and treatment.

2. Letters at periodic intervals to family physician in the nature of a progress note.

3. Final letter giving a summary to the family physician with recommendations for follow-up care and

readjustment to the community and any drugs which should be administered to the patient.

B. Obligation of the family physician to the patient and his family including:

1. Discussion of the patient's prognosis and progress at intervals, determined by receipt of letters from patient's ward physician.

2. Interest in follow-up psychiatric care and readjustment to the community.

3. Interest of the family physician in community mental health programs.

C. Discussion of amending requirements of internships in Georgia to include an obligatory period of time on a psychiatric service.

D. It was suggested that greater first-hand knowledge of existing psychiatric institutional care should be made available to the practicing physicians of Georgia.

E. Discussion of participation of the practicing physicians of Georgia in the medical care of patients of Milledgeville on an in-patient basis.

F. Discussion of the creation at Milledgeville of a nucleus of qualified psychiatrists, whose function would be to stimulate the existing personnel's thinking, to teach future psychiatrists, and to be available as guest lecturers to county medical societies and other interested groups as well as constituting a teaching staff for postgraduate instruction in psychiatry for any of the medical specialties. It was pointed out that by being a teaching psychiatric institution intrinsic to itself and by providing qualified instructors for postgraduate courses in psychiatry and guest lecturers for county societies, there would be created a distinct link between the State Hospital and the many individual statewide communities. It was suggested that, since there were financial problems prohibiting the present institution from having such a teaching nucleus, two alternatives may possibly be investigated. These were:

1. The possibility that the United States Public Health Service may be interested in establishing a teaching and research center at the State Hospital.

2. Possibly some philanthropic organizations may be interested in establishing a program of research in mental health at the hospital thereby providing a teaching nucleus without any appreciable increase in the existing operational cost.

II. It was proposed that a movie be produced depicting an individual in his home environment becoming overtly psychotic; the family physician is consulted; institutional psychiatric care is recommended; the patient is committed to a psychiatric institution with the commitment proceedings shown step-by-step. The patient is admitted to the psychiatric hospital, given a thorough physical, mental, and personality evaluation, given appropriate laboratory studies, presented to a diagnostic clinic, given therapy—medical, psychiatric, occupational, etc.—is shown progressing through the wards, is rehabilitated, is discharged, is referred to the family physician who assumes the role of family advisor and psychiatrist. The movie should be educational, optimistic, and should have a distinctly personal approach.

III. Discussion.

A. The subcommittee agreed to recommend that in-

ternships in Georgia include an obligatory period of time on a psychiatric service.

B. Following discussion of establishment of a teaching nucleus at the State Hospital, it was agreed that the proposal is desirable and should be accomplished. Financial problems at the present time prohibit such an endeavor.

C. Following discussion of letters from the hospital to the family physician, it was stated that the family physician should request appropriate information from the hospital, initially, during treatment, and following dismissal.

D. Regarding the production of a movie, it was agreed that such a project would be worthwhile, and it was approved that such a project would be feasible if it depicted a true picture and if it were subject to approval by the Department of Public Welfare. It was mentioned that Smith, Kline and French is at the present time considering production of a movie depicting the existing psychiatric picture in Georgia.

E. Dr. Allen suggested that once a year the psychiatric page in the *Journal of the Medical Association of Georgia* should include a resume of the expenditures of the State Hospital.

F. Comments on the suggestion that the practicing physicians of Georgia participate in the in-patient medical care at Milledgeville:

1. The limited hours a visiting physician could spend with patients would make the visiting physician's services distinctly limited. The processes of patients' eating, participation in occupational therapy, and general ward activities would decrease the number of hours a given practicing physician could spend with patients, perhaps to a little as six hours per day.

2. Problem of housing for visiting physicians.

3. Problem of increased physical facilities and personnel entailed by a visiting physician.

4. Geographic problem relating to the hospital and Georgia and geographic problems intrinsic to the hospital's getting patients from the individual wards to the examining area and back.

5. Reluctance of the practicing physicians in Georgia to participate in the program due to distaste of dealing with neuropsychiatric patients.

6. Inadequate stenographic force to write up physical examinations.

7. It was stated by Dr. Peacock that in order for the services of a given visiting physician to be of value to the State Hospital, it would be necessary for the visiting physician to spend no less than three days, and this means that the physician would be doing only periodic physical examinations during his tenure.

8. It was suggested by Dr. Allen that a survey be made of the physicians of Georgia to determine the actual number of practicing physicians in Georgia who would participate in such a visiting program.

9. Dr. Peacock discussed the various specialty consultants participating at the present time with the State Hospital including the fields of surgery, obstetrics, gynecology, internal medicine, neuro-surgery, etc.

10. It was pointed out that particularly in the geriatric patient, many chronic geriatric illnesses are so insidious in their development as to be unnoticed by hospital personnel unless periodic physical examinations and appropriate laboratory studies be made; that it is not uncommon in private practice to encounter a non-psychotic geriatric patient who has impairment of recent memory, impairment of affect, etc. The individual receives appropriate medical therapy, his congestive failure reverses, his benign prostatic hypertrophy is corrected along with the attending subclinical uremia and possibly acidosis, and his psychotic or pre-psychotic personality is often returned dramatically toward normalcy.

11. It was suggested that the duties of visiting physicians could be set down in order more efficiently to utilize their services.

12. Dr. Peacock stated that, if the foregoing difficulties could be overcome, he would accept the services of visiting physicians to perform the periodic physical examinations.

Following the report by Dr. Vansant, items requiring action of the committee were discussed.

Concerning item III, sub-section C, it was suggested that this matter be included in the commitment booklet. This concerns the request that the family physician should ask for appropriate information from the hospital, initially, during treatment, and following dismissal.

Concerning item III, sub-section A, the recommendation that internships in Georgia include an obligatory period of time on a psychiatric service, it was voted to pass this on as a recommendation to the Committee on Medical Education and possibly to the Joint Commission on Accreditation.

Concerning the production of a movie on the Milledgeville State Hospital, it was voted to contact Smith, Kline & French Laboratories in regard to their proposed film and request that this committee be allowed to act in an advisory capacity in the production of the film.

The committee also voted to approve the subcommittee recommendation that the Mental Health Page in the *JMAG* should include a resume of the annual report of the Milledgeville State Hospital each year.

Concerning the possibility of practicing physicians' participating in the in-patient medical care at Milledgeville State Hospital, it was voted to conduct a survey of the physicians of Georgia to determine how much time would be given by the physicians in the State and how many physicians in the State would be interested in such a project.

Miscellaneous Items—The committee also discussed the use of psychiatric beds in Hill-Burton Hospitals and voted to contact R.C. Williams and the Georgia Hospital Association to determine how many beds presently are being used for psychiatric purposes in general hospitals in Georgia and also to ascertain other information in regard to this problem. The committee members also discussed the recent statement by Governor Griffin in regard to screening centers and several proposals in the Legislature in regard to studying problems of mental health. Dr. Felder reported on plans for the Mental Health Page to be published in the *Journal of the Medical Association of Georgia*. The

meeting of the new section on Nervous and Mental Diseases to be held at the Annual Session of the Medical Association of Georgia was discussed, and it was pointed out that the commitment booklet would be presented at that time by the committee. Mr. Kiser was authorized to check with Dr. Smith, the program chairman for this section, to work out the details of this part of the program. Dr. Chalmers stated that the annual report of the committee was being prepared and copies would be mailed to all members of the committee for their suggestions prior to publication.

There being no further business, the meeting was adjourned.

Rural Health Committee

J. L. WALKER, CLARKESVILLE, Rural Health Committee Chairman, opened the meeting of the Medical Association of Georgia Rural Health Committee and the Advisory Council to the MAG Rural Health Committee at 1:50 p.m., April 3, 1957, at the Rock Eagle Cafe, Eatonton.

Members of the MAG Rural Health Committee in attendance were: J. L. Walker, Clarkesville; Charles T. Brown, Guyton; H. C. Derrick, Lafayette; and Hugh B. Cason, Warrenton. Also in attendance was Mr. Milton D. Krueger, MAG Executive Secretary.

Members of the proposed Advisory Council to the MAG Rural Health Committee attending the meeting included: The Rev. Edward A. Driscoll, Georgia Council of Churches, 63 Auburn Avenue, Atlanta; Miss Marian Fisher, Asst. 4-H Leader, Agricultural Extension Service, University of Georgia, Athens; Mr. Wm. A. King, District Agent, Extension Building, University of Georgia, Athens; Miss Leah Mae Jarrett, Georgia 4-H Council, Route 1, Rome; Mrs. Rufus Slaughter, Georgia Home Demonstration Council, 301 Walnut Street, Eatonton; and Miss Lucile Higginbotham, Health Education Specialist, Georgia Agricultural Extension Service, Athens.

Dr. Walker reviewed the activity of the MAG Rural Health Committee over the past year and then discussed the purpose of an Advisory Council. He asked the members of the proposed Advisory Council to the MAG Rural Health Committee if they would accept appointments on such a council, and they signified they would. These appointments were then confirmed.

Dr. Walker opened the floor for general discussion. Miss Higginbotham outlined the necessity for a check list describing the best features of good voluntary prepaid hospital and medical insurance. She believed that such a check list would indicate coverage and policies that good voluntary prepaid health insurance plans should include. By general agreement, it was decided that the Rural Health Committee should supply the necessary information on medical and hospital voluntary prepaid insurance and mimeograph a check list as called for above.

Discussion ensued concerning the Salk polio vaccine, and the groups represented volunteered all and any help in aiding the public to take advantage of the vaccine.

The publication *Today's Health* was discussed, and it was recommended that the Auxiliary to the Medical Association of Georgia be asked to make this magazine available to all high schools, etc.

It was also generally agreed that the Association Ru-

ral Health Committee should make available a library of health films and that a film catalogue should be sent to Miss Higginbotham.

A monthly health column to be sent to weekly newspapers by representatives of the group was discussed, and it was generally agreed that such a health column would be advantageous. The preparation of this column was delegated to the Rural Health Committee with the dissemination of the column to be effected by members of the Advisory Council.

Discussion ensued about the seeming lack of liaison between the majority of hospitals and the minister, priest, or rabbi. It was generally agreed that the project of establishing a chaplain service at each of the Hill-Burton Hospitals should be considered and that the Advisory Council would cooperate in this project.

A health record card was discussed, and it was understood that the American Academy of General Practice had discussed such a card. It was then generally agreed that such a card, as soon as obtained from the AAGP, would be extremely helpful and this card could be distributed by the Advisory Council. This activity was approved, and the Rural Health Committee was delegated the responsibility of getting up such a card.

Also discussed was the matter of recruiting paramedical personnel. It was generally agreed that a booklet or brochure should be compiled giving data as to where paramedical training may be obtained, the cost of training, the length of training, the types of careers, the remuneration in such careers, etc. It was suggested that this booklet could be distributed by the Advisory Council to members of the 4-H Clubs, church groups, YMCA, etc.

Dr. Walker described a Rural Health Conference such as other states have held, for the information of the Advisory Council. There being no further business, it was decided by general agreement that the next meeting of the MAG Rural Health Committee and the Advisory Council to the Rural Health Committee would be held September 15 at 12:45 p.m., Academy of Medicine, 875 West Peachtree Street, NE, Atlanta. Mr. Krueger was instructed to call this meeting at least two to three weeks in advance of the date of the meeting.

The meeting was adjourned at 4:20 p.m., and Mr. Krueger was instructed to make the following addendum to the minutes:

APPLE PIE

(With no apples needed)

- 2½ Cups of Sugar
- 2 tsp. Cream of Tartar
- 2 cups Water
- 22 Ritz Crackers
- 1 tsp. Allspice

Add sugar, cream of tartar, water and bring to a boil. Drop in the 22 ritz crackers, do not stir. Boil 2 minutes. Remove from heat and pour into uncooked pie shell. Cook 45 min. in oven 350°.

Suggestions for Health and Safety Project Chairmen

Compiled by

Miss Lucile Higginbotham
Health Education Specialist

1. Appoint county and community health and safety project chairmen.

2. Hold a leader training meeting for health and safety project chairmen.
3. Conduct health and safety campaigns on: clean-up, fix-up, paint-up and home safety.
4. Cooperate with approved health drives.
5. Learn and use the services of your county health department.
6. Present health education programs on: heart, cancer, home safety, mental health, weight control, adequate diet, health insurance, and care of teeth and eyes.
7. Encourage all families to choose a family physician.
8. Emphasize the importance of regular medical examinations.
9. Encourage all families to have the necessary immunizations.
10. Plan for a series of health forums in cooperation with your county medical society.
11. Promote traffic safety programs, such as: vision testing, pedestrian safety, motor vehicle inspection, state traffic laws and regulations, driver training courses, periodic re-examination of all drivers, bicycle safety.
12. Distribute leaflets and other literature on health and safety.
13. Arrange exhibits and displays on health and safety.
14. Show films on health and safety.
15. Write newspaper articles on health and safety with information from doctors, dentists, nurses, and others.
16. Present radio and television programs on health and safety.
17. Sponsor the 4-H health project in your community.

Executive Committee of Council

CHAIRMAN GEORGE DILLINGER called the meeting of the Executive Committee of Council to order at 10:15 a.m., April 14 at the Academy of Medicine, Atlanta.

Members of the Executive Committee in attendance were as follows: Hal M. Davison, Atlanta, President; W. Bruce Schaefer, Toccoa, President-Elect; David Henry Poer, Atlanta, Secretary-Treasurer; J. G. McDaniel, Atlanta, Chairman, Finance Committee; and George R. Dillinger, Thomasville, Chairman of Council.

Also in attendance were Rives Chalmers, Chairman, MAG Mental Health Committee; Edgar Woody, Jr., Editor, *Journal of the Medical Association of Georgia*; Mr. John Dunaway, MAG Counsel; Exum Walker and the Messrs. Milton D. Krueger, and John F. Kiser, MAG Executive Secretaries.

Mr. Krueger reviewed minutes of the Council meeting, March 9-10, 1957, Radium Springs Resort, and the minutes of the Executive Committee of Council Phone Call Conference, March 14, 1957, which were approved as read.

Veterans Affairs Committee Fee Schedule Recommendation—Correspondence was presented concerning Medical Association of Georgia contract V-1001-M-71 dated June 29, 1948, with the Veterans Administration concerning a fee schedule for physicians in the State of Georgia rendering medical service in such cases as may be specifically authorized by the Veterans Administration. This fee schedule had been forwarded to Hartwell

Joiner, Chairman of the Association Veterans Affairs Committee, for consideration before renewal in June, 1957. Dr. Joiner was asked to review the whole fee schedule and make any suggestions. Dr. Joiner recommended that all fees contained in this fee schedule should be increased from 25 to 33 1/3 per cent over the rate now in effect for the contract.

It was moved that the schedule should be referred to the Veterans Affairs Committee and be gone over "fee by fee" so that each could be corrected individually, if necessary, and that this fee schedule be returned with recommendations as soon as possible. Motion approved.

MAG Building Committee Report—The action of the Board of Trustees of the Fulton County Medical Society, April 3, 1957, was read. In essence the action stated that the Fulton County Medical Society Board of Trustees believed that to rent, lease, or sell ground to the Medical Association of Georgia to erect a headquarters building on Fulton County Medical Society property or provide additional space by altering the present building was considered inadvisable by the Fulton County Board of Trustees. It was moved that this matter be referred to the April 27, 1957, Council meeting. Motion approved.

Hospital Care Council Appointments—Correspondence from Thomas F. Sellers, Director of the State Health Department, requested (in accordance with the Hospital Care for the Indigent Law, Act 397, Georgia Laws 1957) that the Medical Association of Georgia provide four nominees from among the membership of the Association, two for each appointment provided for in the Act, to serve on the Hospital Care Council. It was moved that the first appointment be made from nominees Milford B. Hatcher, Macon, and W. L. Pomeroy, Waycross, and that the second appointment be chosen from Bruce Schaefer, Toccoa, and A. B. Conger, Columbus. This motion was approved, and Mr. Krueger was instructed to so notify the State Department of Health.

Professional Conduct—The report of the Professional Conduct Committee meeting Sunday, April 7, 1957, was read, and the following action ensued:

(1) On motion the letter submitted by the Professional Conduct Committee addressed to Mrs. Louis F. Poole, Jr., was approved for transmittal, and this motion was then approved.

(2) In regard to the recommendation of the Professional Conduct Committee to the study of physician's responsibility and that of the nurse, the following motion was made: that the Professional Conduct Committee be requested to present a resolution to the House of Delegates covering their recommendations about personnel administering medical treatment without M.D. authorization. Motion approved.

(3) The Athens case was discussed, and as no action was requested by the Professional Conduct Committee, the matter was accepted merely as information.

(4) The Fulton County Medical Society problem concerning Workmen's Compensation had been referred to the Council by the Professional Conduct Committee, after discussion it was the opinion of the Executive Committee that the Fulton County Medical Society Board of Trustees acted correctly on this matter, and further that the Executive Committee wishes to refer this matter further to the MAG In-

dustrial Health Committee and the Council Workmen's Compensation Committee for information only. Motion approved.

Medical Defense Experience—Attorney John Dunaway and Exum Walker discussed with members of the Executive Committee certain problems apparent in professional liability cases. It was moved that the Chairman of Council appoint a committee to confer with Mr. Dunaway and Dr. Walker concerning procedures in the early preparation of professional liability cases. This motion was approved. The chairman appointed David Henry Poer chairman of this special Professional Liability Committee, and Bruce Schaefer and J. G. McDaniel as committee members.

Expert Medical Testimony—Mr. Dunaway reported on the recent Georgia Supreme Court decision in the Shea case which gives clear indication that Georgia trial judges will be governed strictly by expert medical testimony by physicians in matters of diagnosis and treatment and further, unless there is in fact expert medical testimony which would measure the standard of the physician on trial, a jury would not be permitted to say whether or not the standard had been violated. On motion the Executive Committee voted their appreciation to Counsel and to the many others who supported this position.

Mental Health Committee Report—Rives Chalmers, Chairman of the MAG Mental Health Committee, reported on a 20-page booklet prepared by his committee on the subject of "Hospitalization of the Mentally Ill". Aiding in the preparation of the booklet was the Georgia Bar Association. Dr. Chalmers asked approval for the use of the Association seal and name on the brochure and an appropriation of funds to cover the publication of the brochure. It was moved that pending final authorization, the Executive Committee of Council approve the use of the Association seal and name and further approved the expenditure of up to \$400 to be charged to the reserve fund to cover the cost of publishing 5,000 booklets; it further recommended that the committee seek financial assistance from the Mental Health Association on this project. Motion approved. It was moved that Dr. Poer and Dr. Woody be authorized to give final approval of the subject matter in this booklet, allowing the use of the Association seal and name on the booklet. Motion approved.

Dr. Chalmers told the Executive Committee of Council about a movie film being produced by Smith, Kline and French and the State Welfare Department on the subject of the Milledgeville Hospital. Dr. Chalmers wished instruction as to whether or not the Association Mental Health Committee could co-sponsor such a film showing the family doctor's position in referring patients to Milledgeville State Hospital. It was moved that the MAG approve and co-sponsor such a film as discussed by Dr. Chalmers. Motion approved.

MAG Journal Report—Edgar Woody, Jr., Editor of the *Journal of the Medical Association of Georgia* reported on a conference with the printing firm of Higgins-McArthur, printers of the Association's Journal. He reported that the relationship between the Association and this firm was an improving relationship and that this conference discussed the past year's accomplishment and arrangements. Dr. Woody also reported that this firm is requesting a five per cent increase on *Journal* printing, as they believe their increased cost in paper,

labor, and equipment justifies their request. Dr. Woody reported that in the past year the advertising revenue has been increased and that he believes the *Journal* can absorb this increase. It was moved that the Executive Committee of Council recommend that the five per cent increase be granted at the request of the printing firm of Higgins-McArthur and that this take effect as of June 1, 1957, and further that this recommendation be referred to the 1957-58 Council at the organizational meeting May 1, for action. Motion approved.

Medicare Report—Dr. Poer gave a resume of the progress to date in processing and paying claims under the Dependent's Medical Care Act, Public Law 569. He related that the program was three times larger than anticipated and will probably get larger. Criticism from certain MAG members was discussed, and Dr. Poer expressed the opinion that the Association should consider discontinuing to act as its own fiscal agent and think of sub-contracting this part of the program. Mr. Krueger related that the Association, even if it did not act as its own fiscal agent, would still have to review and adjust claims and continue to be responsible for the policies of the program, and for informing doctors about the program. Mr. Krueger expressed confidence in the team employed by the Association to administer the program. The matter was referred to the full Council for consideration. A resolution made at the last meeting of the Medicare Review Board was discussed and referred to the full Council for action and the resolution is as follows: "That the Medicare Review Board recommend to the Council of the Medical Association of Georgia that the problems of administrative expenditures in operation of the Medicare program be determined by said Review Board insofar as they do not exceed the allowable costs per claim rate." This motion was received for information only at this time, and referred to Council for consideration.

Ellijay Hospital Problem—A problem concerning the operation of a Hill-Burton Hospital in Ellijay, Georgia, was thoroughly discussed by the Executive Committee of Council. It was moved that this problem be referred to the Hospital Committee of the Association for recommendation back to the Council of the Medical Association of Georgia and that this recommendation be received by the April 27 meeting of the Council. The motion further requested that this problem also be referred to the Advisory Committee to the Hill-Burton program. This motion was then approved.

AAPS Essay Contest—Correspondence from the Association of American Physicians and Surgeons requesting that the Medical Association of Georgia cooperate in an "essay contest" recommended by this group was presented and discussed. It was moved that because of the extremely busy calendar of events requiring Association participation that the Association, at this time, could not participate in such a program to the extent required, and as such, would not be in a position to sponsor such an essay contest. Motion approved.

Conference of Presidents—A statement in the amount of \$75.00 from the Conference of Presidents and other officers of State Medical Associations was presented to the Executive Committee along with recommendations from the three MAG-AMA Delegates on this matter. It was moved that the Association not participate in this organization at this time because of certain fiscal difficulties. Motion approved.

Certificates of Appreciation—Chairman Dillinger asked members of the Executive Committee to select outstanding physicians who have contributed most outstanding service to the Association during the year 1956-57 so that these physicians may be awarded "Certificates of Appreciation" at the 1957 Annual Session. It was approved that the following men be awarded Certificates of Appreciation for their outstanding service to the Association: Harry L. Cheves, Union Point,—for service on the Council of the Medical Association of Georgia; J. Calvin Weaver, Atlanta, Ga.—service as Chairman of the History and Vital Statistics Committee; Hal M. Davison, Atlanta, Ga.—service to the Association as President, 1956-57; and David Henry Poer, Atlanta— for service to the Association as Secretary-Treasurer, 1951-57.

It was moved that the Executive Committee recommend to the Council of the Medical Association of Georgia the appointment of a committee for the establishment of an Association distinguished service award, and further that this committee carefully study the basis of selection for such an award, and so report back to the Council within six months of their appointment. Motion approved.

Duplicating Machine—Mr. Krueger informed the Executive Committee about the need for a copy machine and related experience with Thermo-Fax equipment which had been rented by the Headquarters Office during a trial period. Mr. Krueger stated that this machine sells for \$329.00 and can be purchased at a reduced price and asked consideration of the purchase

of this equipment. It was moved that the Thermo-Fax machine be purchased, and that such expenditure up to \$250 be charged to the reserve fund.

Unfinished Business—Mr. Krueger discussed certain electrical wiring problems in connection with the 1957 Annual Session, for information only.

New Business—A communication from Harry Pinson in behalf of the Student American Medical Association Chapter at the Medical College of Georgia was read, in which this organization sought approximately \$150 to \$200 to aid in underwriting the expenses of one delegate to the annual meeting of the SAMA. The matter was thoroughly discussed, and by general agreement it was recognized that because of fiscal difficulty and the shortness of the notice, that this disbursement could not be approved. It was felt that this matter should be referred to the Finance Committee for study for ensuing years, and Mr. Krueger was instructed to forward this data to the Finance Committee for consideration for subsequent years.

A statement concerning professional liability and medical defense service from the Association Counsel in behalf of Augustus H. Frye, Jr., was presented and it was noted that the suit was filed before the May 15, 1956, change in the Constitution and By-Laws, and by action of the Executive Committee of Council, March 14, the Association is liable for service, and the charge in the amount of \$150 was approved for payment to Mr. Dunaway.

There being no further business, the meeting was then adjourned at 2:10 p.m.



Physician Lawmakers

Pictured above are four physicians who serve in the 1957-58 State Senate. Standing on the Rostrum of the President of the Senate, they are, left to right, Marcus Mashburn, of Cumming; Frank Holder of Eastman; H. M. Edge of Blairsville and C. J. Roper of Jasper. Dr. Mashburn served as chairman of the Senate Health and Welfare Committee and also served on the important Rules Committee and the Penal and Correctional Affairs Committee.

Dr. Holder served on the Appropriations Committee, Health and Welfare Committee and the Temperance Committee. Dr. Edge served on the County and Municipal Governments Committee, the Finance Committee and the Health and Welfare Committee. Dr. Roper served on the Finance Committee, Health and Welfare Committee and the Defense and Veterans Affairs Committee.

New Members of The Medical Association of Georgia

<i>NAME</i>	<i>ADDRESS</i>	<i>CLASSI- FICATION</i>	<i>COUNTY SOCIETY</i>
Hugh Lumpkin Coffee	63 W. Johnston St., Forsyth	Active	Bibb
Charles H. Field	700 Spring St., Macon	Active	Bibb
Hubert U. King	Bulloch County Health Dept., Statesboro	Active	Bulloch-C-E
William R. Thompson	Summerville	Active	Chattooga
John H. Thurmond	Palmetto	Active	Coweta
Morris N. Dalton	Hailey Bldg., Hartwell	Active	Franklin-Hart
George Adams	50 7th St., N.E., Atlanta 23	Service	Fulton
Robt. John Anderson	50 7th St., N.E., Atlanta 23	Service	Fulton
Warren Franklin Brown	936 Canton St., Roswell	Active	Fulton
Bartlette Martin Cheatham	Emory University Hosp., Emory University	Active	Fulton
Hugh B. Cottrell	50 7th St., N.E., Atlanta 23	Service	Fulton
Edwin D. Crane, III	36 Butler St., S.E., Atlanta 3	DE 2	Fulton
Waldo E. Floyd, Jr.	36 Butler St., S.E., Atlanta 3	DE 2	Fulton
William S. Hagler	36 Butler St., S.E., Atlanta 3	DE 2	Fulton
Edwin P. Lochridge, Jr.	1293 Peachtree St., N.E., Atlanta 9	Active	Fulton
Tom Daniel Raaen	36 Butler St., S.E., Atlanta 3	Active	Fulton
Marvin Benton Slocumb	12 Capitol Sq., S.W., Atlanta 3	Associate	Fulton
Jean S. Staton	36 Butler St., S.E., Atlanta 3	DE 2	Fulton
Ted L. Staton, Jr.	36 Butler St., S.E., Atlanta 3	DE 2	Fulton
Julius Wenger	5998 Peachtree Rd., N.E., Atlanta 19	Service	Fulton
Bert Hale Ellis	3043 Sherwood Dr., Brunswick	Active	Glynn
Jesse L. Hunt	1514 Union St., Brunswick	Active	Glynn
Carl W. Lupo	Marshall Bldg., Ocean Blvd., St. Simons Island	Active	Glynn
Woodrow W. Payne	Brunswick	Active	Glynn
Roy Frank Thagard	509½ Gloucester St., Brunswick	Active	Glynn
Bill Martin Bailey	333 1st Ave., N.E., Cairo	Active	Grady
Asa William DeLoach	311 N. Broad St., Cairo	Active	Grady
Jack Wallace Whitworth	Greenville	Active	Meriwether- Harris
Raymond Daniel Evans, Sr.	Clayton	Active	Raburn
Solomon K. Brown	1467 Harper St., Augusta	Active	Richmond
Joseph D. Lee	901 Heard Ave., Augusta	Active	Richmond
William T. Lucas	1142 Druid Park Ave., Augusta	Active	Richmond
Henry Arthur Foster	124 W. Popular St., Griffin	Active	Spalding
John Lamar King	8th St., Griffin	Active	Spalding
James William Watkins, Jr.	923 Belvoir Ave., Chattanooga 4, Tennessee	Active	Spalding
William Vance Watt	900 Gordon Ave., Thomasville	Active	Thomas-Brooks
Edward D. Wells, Jr.	301 N. Lewis St., LaGrange	Active	Troup
Norman P. Gardner	101 Ave. F., Thomaston	Active	Upson
David M. Nowell	Alabama St., Dalton	Active	Whitfield
Wilbur Edwin Baugh	P. O. Box 28, Gordon	Active	Baldwin
Mary K. McMillan Hires	Milledgeville State Hosp., Milledgeville	Active	Baldwin
Charles C. Stewart	P. O. Box 31, Donalsonville	Active	Decatur- Seminole
Paul S. Kemp	Bathey State Hosp., Rome	Active	Floyd
James Moultrie Lee	2420 Abercorn St., Savannah	Active	Ga. Medical
Joseph H. McCormick, Jr.	117 E. Jones St., Savannah	Active	Ga. Medical
Morris L. Miller	3601 Bull St., Savannah	Active	Ga. Medical
Ray Darwin Webb	Springfield	Active	Ga. Medical
Augustus F. Bloodworth	401 E. Broad St., Gainesville	Active	Hall
Benjamin F. Moss, Jr.	University Hospital, Augusta	Active	Richmond
Dillard L. Nix	1010 Prince Ave., Athens	Active	Crawford W. Long
Freeman Hamilton Cary	2561 N. Decatur Rd., Decatur	Active	DeKalb
Frederick Boone Jones	231 E. Ponce de Leon Ave., Decatur	Active	DeKalb
Halcott Townes Haden	46 Fifth St., N. E., Atlanta 8	Active	Fulton

INFORMATION

ANNOUNCEMENTS

Courses

9th Postgraduate Assembly in Endocrinology and Metabolism—October 21-25, 1957, Medical College of Georgia, Augusta, Ga. Faculty will consist of 22 clinicians and investigators in the fields; course is designed to cover the main aspects of diagnosis and therapy for the physician in general practice. Approved by the AAGP for 35 credit hours in Category I. For further information concerning the program and registration, write to Dr. Robert B. Greenblatt, Dept. of Endocrinology, Medical College of Georgia, Augusta, Ga. Registration is limited to 100; tuition fee is \$100.00. Rooms will be reserved for students and faculty at the Bon Air Hotel. Residents and fellows will be admitted for \$35.00.

Cardiovascular Research Training Program—Beginning July 1, 1957, Medical College of Georgia, Augusta. Five post-doctoral students will be enabled to receive an intensive training in cardiovascular research under the direct supervision of William F. Hamilton, professor of physiology, and Raymond P. Ahlquist, professor of pharmacology. A stipend of \$3,400 plus \$350 for each dependent and certain expenses will be provided to participants who will be given time to read classical and current research reports. Inquiries and requests for application forms should be addressed to either of the directors of the program, Dr. Hamilton or Dr. Ahlquist, Medical College of Georgia, Augusta, Ga.

Seminar on Hematology—June 20-22, 1957, College of Medicine, University of Florida, Gainesville, Fla. Steven O. Schwartz, professor of hematology at the Chicago Medical School, will be the principal lecturer. Course will be given in the Science Building of the College of Medicine beginning on Thursday, June 20, and ending at noon on Saturday, June 22. Advance registration is solicited. Fee is \$25.00. Information and program details may be secured by writing the Director, Division of Postgraduate Education, 1625 Riverside Ave., Jacksonville, Fla.

25th Annual Graduate Short Course—June 24-28, 1957, Science

Building, College of Medicine, University of Florida. The first three days will be devoted to lectures on medicine by James V. Warren, M.D., professor of medicine at Duke University School of Medicine; pediatrics, by McLemore Birdsong, M.D., professor of pediatrics, University of Virginia; Laboratory Diagnostic Methods by the staff of the College of Medicine, University of Florida. The last two days will be confined to lectures on surgery by James R. Cantrell, M.D., assistant professor of surgery, The Johns Hopkins University School of Medicine, and gynecology, by Howard W. Jones, M.D., assistant professor of gynecology, The Johns Hopkins University School of Medicine. For the program write to the Director, Division of Postgraduate Education, 1625 Riverside Ave., Jacksonville, Fla. Fee for registration: \$10.00. Approved by AAGP for Category I hours.

Four courses in ophthalmology for specialists—New York University Post-Graduate Medical School: (1) *Histopathology*—part-time course from September 16-20, 1957, given under the direction of A. Marvin Gillman, M.D.; (2) *Surgery of the Eye*—fulltime course from October 28-November 2, 1957; (3) *Ophthalmoscopy*—A part-time course from November 4-8, 1957; and (4) *Surgery of the Cornea*—full-time course from December 2-6, 1957. For further information, write to the Office of the Associate Dean, N. Y. U. Post-Graduate Medical School, 550 First Ave., New York 16, N. Y.

Eight Week Course in Occupational Medicine—September 16, 1957, through November 8, 1957, N. Y. U. Post-Graduate Medical School. For further information write: Office of the Associate Dean, N. Y. U. Post-Graduate Medical School, 550 First Ave., New York 16, N. Y.

Films Available

"The Medical Witness" and *"The Doctor Defendant"*—The A. M. A. and the American Bar Association have joined forces for the first time to present a series of educational films on "Medicine and the Law" dealing with the professional relationships of doctors and lawyers.

Each film runs 30 minutes, is black and white with sound, on 16 mm. film. The series is produced by The William S. Merrell Co., Cincinnati, Ohio, as a service to the medical and legal professions. Societies desiring to show either or both films may write to the Film Library, A. M. A., 535 North Dearborn St., Chicago 10, Ill.

"Meti" Steroids in Rheumatoid Arthritis—A new 16 mm. color motion picture on the uses of steroids in the treatment of rheumatoid arthritis has been released for showing to professional groups by the research division of Schering Corporation. The film runs 25 minutes and is the fourth in Schering's series on hormone therapy and the endocrines. It is available on loan from the Audio-Visual Dept., Schering Corp., Bloomfield, N. J.

"Urine Sugar Analysis for Diabetics"—The film was made as a visual aid to be used in the education of diabetic patients and shows the relationship between carbohydrates and insulin. Produced on 16 mm. film in color and sound track with a running time of approximately 10 minutes. Showings at diabetic clinics, diabetic lay societies and other diabetic groups must be requested by the medical or allied professions to Ames Company, Inc., Elkhart, Ind., or an Ames representative.

Meetings

District IV, American College of Obstetricians and Gynecologists—October 4 and 5, 1957, Washington, D. C. The areas comprising this district are: D. C., Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia, Puerto Rico, and the Virgin Islands. Physicians are invited to attend the scientific and social functions of the meeting; additional information may be obtained by writing Frank R. Lock, M.D., Bowman Gray School of Medicine, Winston-Salem, N. C., District Chairman, or Robert H. Barter, M.D., 901 - 23rd St., N.W., Washington, D. C., Chairman of the Program.

23rd Annual Meeting of the American College of Chest Physicians—May 29-June 2, 1957, Hotel Commodore, New York City. There will be formal presentations, symposia, round table luncheon discussions, seminars, and motion pictures on all aspects of heart and lung diseases.

(Announcements)

Examination for fellowship in the college will be held on Thursday, May 30. On June 1, more than 150 physicians will receive their certificates of fellowship at the annual Convocation, which will precede the Presidents' Banquet. Copies of the program may be obtained by writing to the Executive Offices, American College of Chest Physicians, 112 East Chestnut St., Chicago 11, Ill.

Annual Assembly in Otolaryngology, University of Illinois College of Medicine—September 30-October 6, 1957, Section of Otolaryngology, Univ. of Ill. College of Medicine. The Assembly will consist of an intensive series of lectures and panels concerning advancements in otolaryngology, and evening sessions devoted to surgical anatomy of the head and neck in histopathology of the ear, nose and throat. Interested physicians should write direct to the Department of Otolaryngology, 1853 West Polk St., Chicago 12, Ill.

Seventh American Congress on Maternal Care—July 8-12, 1957, Palmer House, Chicago. The congress, under the leadership of F. Bayard Carter, M.D., professor and head of the department of obstetrics and gynecology at Duke University, and Samuel B. Kirkwood, M.D., Commissioner of Public Health for the Commonwealth of Massachusetts and professor of maternal health at Harvard Medical School, will present topics dealing with the interprofessional approach to maternal and infant care. Further information can be obtained by writing: The American Committee on Maternal Welfare, 116 South Michigan Ave., Chicago 3, Ill.

Miscellaneous

Deadline for submission of abstracts of papers for presentation at the American Heart Association's Scientific Sessions—June 15. Papers intended for presentation must be based on original investigations in, or related to, the cardiovascular field. Abstracts must be submitted in triplicate on forms obtainable from the Medical Director of the association, 44 East 23rd St., New York 10, N. Y.

American Medical Golfing Association 41st Tournament—June 3, 1957, Westchester Country Club, Rye, N. Y. Tournament play will start at 8:30 A.M. Players may tee

off up to 2:00 P.M. Buffet luncheon, banquet, prizes and green fees are included in the cost of the day's activities (not announced). Notice of further details and advance registration card may be secured by writing Bob Elwell, 3101 Collingwood Blvd., Toledo 10, Ohio.

Free Cardiac Surgery Program—National Jewish Hospital, Denver, Colo., will consider applications for admission in behalf of patients suffering from cardiovascular defects amenable to surgical intervention, including mitral and aortic stenosis, congenital anomalies, etc. Patients are accepted without respect to race, religion, or national origin, and without charge. Only those *unable* to pay for private care are eligible. Inquiries should be sent to the Medical Director, National Jewish Hospital, Denver 6, Colorado.

DEATHS

ROGER W. DICKSON, Atlanta, died on February 21, 1957. His body was found in the Chattahoochee River; his death was apparently the result of suicide by drowning. It was reported that Dr. Dickson had been despondent since suffering a heart attack last June. He was 60 years old at the time of his death.

Dr. Dickson was born near Fitzgerald; he received his B.S. degree in 1918 from the University of Georgia and his M.D. degree summa cum laude from Emory University School of Medicine. He interned at Philadelphia General Hospital, 1922-24, and was resident at Children's Hospital of Philadelphia, 1924-25. He had practiced pediatrics in Atlanta since 1925, serving as chief of pediatric service at Grady Memorial Hospital, Atlanta, from 1944 to 1951. He was professor of pediatrics at Emory University School of Medicine and past chairman of the department of pediatrics. He asked to be relieved of his full-time duties at Emory and Grady in 1951 but was still in private practice at the time of his death.

Dr. Dickson was a fellow of the American Academy of Pediatrics, a licentiate of the American Board of Pediatrics, a member of the Georgia Pediatrics Society, and a member and past president of the Fulton County Pediatrics Society. Dr. Dickson was a member of the Fulton County Medical Society and served on the boards of trustees of the Georgia and

Atlanta Associations for the Help of Retarded Children. He was also a member of St. Mark Methodist Church, the Aesculapius Honorary Medical Society, Phi Rho Sigma medical fraternity, Alpha Tau Omega social fraternity, and the Capital City Club.

He is survived by his wife, the former Miss Enid Boyce; a daughter, Mrs. William Parker, Big Springs, Texas; a sister, Mrs. J. C. McMillan, Fitzgerald; and his stepmother, Mrs. Marion Dickson, Fitzgerald.

THOMAS HARTLEY HALL, Macon, died on March 5, 1957, at the age of 84. He had practiced medicine in Macon for more than 54 years.

Dr. Hall was born in Macon and was graduated from the Atlanta College of Physicians and Surgeons, now Emory University School of Medicine, in 1903. In 1920, with the late Robert Rozar, he founded the Oglethorpe Private Infirmary, which is now known as the Parkview Hospital. Dr. Hall specialized in diseases of the eye, ear, nose and throat. He served on the staffs of the Macon Hospital and Williams Sanitarium. He had served as physician for the Appleton Church Home, the Georgia Academy for the Blind, the Southern Railway, and the Georgia Railway.

Dr. Hall was a member of Christ Episcopal Church, a former member of Rotary Club, a member of the Idle Hour Country Club, Elks Club, and he was a member and past president of the Bibb County Medical Society.

He is survived by one son, Mr. Thomas Hartley Hall, Jr.; a grandson, T. H. Hall, III; a sister; and several nephews.

IRA MALCOLM GIBSON, 48, Valdosta, died of a heart attack on March 31, 1957.

A native of Batesville, Indiana, he attended Indiana University and the University of Chicago. He taught at Emory University School of Medicine before going to Valdosta 11 years ago.

Dr. Gibson was a member of the First Methodist Church, Rotary Club, Valdosta Country Club, and the South Georgia Medical Society.

Survivors include his wife, two sons and his mother. Funeral services were held in Valdosta, with burial in Sunset Hill.

(Deaths)

HUGH MONTGOMERY LOKEY, Atlanta, died on February 23, 1957, at the age of 80. Although in declining health for the past several years, he continued in the active practice of medicine until a few weeks before his death.

Dr. Lokey was a past president of the Fulton County Medical Society and a Life Member of the Medical Association of Georgia. He was a former president of both state and local eye, ear, nose, and throat societies, and a member of the Georgia Committee of the Gorgas Memorial Institute of Tropical and Preventive Medicine, a fellow of the American College of Surgeons, a trustee-emeritus of the Good Samaritan Clinic, and one of the charter members of the American Academy of Otorhinolaryngology.

Dr. Lokey was born in Centre, Ala., and came to Atlanta as a young man to attend the Atlanta College of Physicians and Surgeons, now Emory University School of Medicine.

After his graduation in 1900, he practiced at Coosa, near Rome, for a year before returning to Atlanta to enter the office of the late Abner W. Calhoun and his son Phinzy Calhoun, with whom he was associated for several years before opening his own office.

Surviving Dr. Lokey are his wife, the former Miss Rebecca Hamilton; three sons, the Messrs. Hugh M. Lokey, Jr., Hamilton and Charles Lokey; a daughter, Mrs. Harold Martin, all of Atlanta; and 13 grandchildren.

GEORGE STEWART MURRAY, Columbus, died on March 31, 1957, at the age of 78.

Dr. Murray was born in Bo'ness, Scotland, and was educated at Daniel Stewart's College and the University of Edinburgh, Scotland. He received his medical degree in 1905 and later studied in Vienna, Austria. Dr. Murray came to the United States and in 1910 began his practice of medicine in Columbus. He served with the British Army during World War I and became a U. S. citizen in 1929. He was at one time chairman of the staff at Columbus City Hospital, president of the Rotary Club, the Executives Club and was for many years a member of the Muscogee County Medical Society, Columbus Country Club, and the Candun Club. He took part in many civic activities: he was chairman of

the Julius Friedlaender Fund Committee, an educational agency which sponsors public lectures for which admission is not charged; he was a member of the Columbus Board of Public Safety; and he was president of the Columbus Philharmonic Guild. He was also a communicant of the First Presbyterian Church.

Dr. Murray is survived by his daughter, Mrs. Jean Smenner, Manchester; a son, Mr. Ronald M. Murray, Los Angeles, Calif.; and three grandchildren.

JAMES LEMUEL NEVIL, 75, of Metter, died at his home on April 5, 1957.

A native of Bulloch County, Dr. Nevil came to Candler County as a young physician and had practiced medicine there since. He was graduated from the Medical College of Georgia and attended Mercer University. He was a member of the Tri-County Medical Society.

Funeral services were conducted on April 7, 1957, at the Metter Primitive Baptist Church, with burial in the Lower Lotts Creek Cemetery. Survivors include his wife, the former Miss Gerstle DeLoach; a sister, Miss Sally Nevil, Savannah; a son, Mr. James Lemuel Nevil, Jr., Savannah; and several nieces and nephews.

CHARLES O. WILLIAMS, West Point, died unexpectedly at his home in West Point on March 22, 1957.

Dr. Williams was born in Harris County on June 10, 1883. He began his practice, after graduating from the Atlanta College of Physicians and Surgeons, in 1906 and came to West Point to practice in 1910. Dr. Williams was a Life Member of the Medical Association of Georgia, a member of the First Methodist Church, of which he had served as steward for many years, and an active member of the West Point Rotary Club.

Funeral services were held at the First Methodist Church of West Point with burial in Marseilles Cemetery.

Survivors include his wife, the former Mrs. Virginia Parker; a brother and two sisters, and several nieces and nephews.

JOSEPH D. ZACHARY, Gray, died on April 6, 1957, after a long illness.

A native of Little Rock, Ark., Dr. Zachary had been a practicing physician in Jones County for 46 years.

He was a member and a deacon of the Gray Baptist Church, a Mason and a Shriner, and was a past president of the Jones County Kiwanis Club.

Surviving are his wife, the former Miss Ethel Glawson, Gray; a daughter, Mrs. William Beeland, Gray; two sisters, and several nieces and nephews.

SOCIETIES

The semi-annual meeting of the **SECOND DISTRICT MEDICAL SOCIETY** was held at 3 p.m., April 4, 1957, at the Bainbridge Club, Bainbridge, Georgia. Scientific papers presented included: (1) "New Drugs in Diabetes" by Fred Chaney, Moultrie, and (2) "The Present Status of Cardiovascular Surgery" by William A. Hopkins, Atlanta. Hal M. Davison, president of the Medical Association of Georgia, spoke briefly on the activities of the Association. Mr. Milton D. Krueger, Executive Secretary of the MAG, briefly outlined the significant activities of the headquarters office. Maurice F. Arnold, Hawkinsville, President of the Georgia Academy of General Practice, discussed the progress and future of the Academy and emphasized its aims and purposes. Mr. Tom Hendricks, Chicago, Illinois, Field Director, American Medical Association, spoke on the subject "Consider the Turtle, What's in the AMA For You?". The nominating committee of the Second District Medical Society made the following nominations which were unanimously approved: Frank Gibson, Bainbridge, president; Fred Chaney, Moultrie, vice-president; and Julian B. Neel, Thomasville, secretary-treasurer. The afternoon session was followed by a social hour and dinner, at which Mr. Chaney Griffin, Bainbridge, Georgia, Mayor of Bainbridge, addressed the District.

The **SIXTH DISTRICT MEDICAL SOCIETY** at a recent meeting in Milledgeville has come up with a suggestion concerning dues which might be adopted by other medical societies. Sixth District Society has voted that district dues will be collected at the same time the county society dues are collected and by the county society secretary, this saving a lot of headaches for the secretary of the district society and also cutting down on the number of

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checks that physicians must write for dues to the various medical organizations. Thus the member-physician would simply write one check a year to his county society secretary for his county society dues, district dues, MAG dues, and AMA dues. After this procedure has been in effect now for approximately a year in the Sixth District, the Society went on record at its last meeting, April 10, Milledgeville, as recommending that this be brought to the attention of the district societies for their information.

The SEVENTH DISTRICT MEDICAL SOCIETY met at the Coosa Club on Wednesday, April 3, 1957. Paul Reaser, Dalton; and William Bondurant, Walter Bloom, and Robert Mabon, all of Atlanta, presented scientific papers. Tom Harbin, Rome, gave the address of welcome, and Ralph Johnson, Rome, president of the society, presided. Following the program, the Floyd County Medical Society entertained with a barbecue. Cecil Elliott, the out going secretary, was elected president-elect, and G. L. Broadrick assumed the office of president.

The BIBB COUNTY MEDICAL SOCIETY met on April 2, 1957 at Pinebrook Inn, Macon. The scientific session, following dinner at 7:30, featured some "Comments on the Safe Conduct of the Cardiac through Surgery" by R. Bruce Logue, Atlanta. Waddell Barnes, chairman of the Program Committee, arranged for the speaker. At the previous meeting of the society the members voted in favor of the medical profession's being included in the Social Security Program; approved the program of immunization of adults between ages of 20 and 40 with Salk vaccine; and heard a discussion by local physicians on "Pyelonephritis." The panel included Herbert Olrick, Ben Bashinski, Jr., and W. H. M. Weaver. Two additional members were appointed to the Advisory Staff for the Crippled Children's Clinic; they are Devereaux Jarratt, ophthalmologist, and Claude Pennington, otolaryngologist.

At a recent meeting of the DEKALB COUNTY MEDICAL SOCIETY Carl C. Pfeiffer, chairman of the department of pharmacology, Emory University, discussed new concepts in the biochemical approach to the treatment of psychi-

atric patients. His remarks were made in a discussion of the new tranquilizing drugs and their effect on mentally disturbed patients and the use of these drugs in everyday practice to relieve anxiety.

The principal speakers at the April meeting of the FULTON COUNTY MEDICAL SOCIETY were the Rev. Thomas H. McDill, professor of practical theology and pastoral counseling at Columbia Theological Seminary; William Rottersman, Atlanta psychoanalyst; and Herbert S. Alden, Atlanta dermatologist, whose paper was read by Homer Swanson in his absence due to illness. The three took part in a symposium on the spirit, philosophy and mind of man.

At the April meeting of the WARE COUNTY MEDICAL SOCIETY, Arthur M. Knight, Jr., Waycross, presented a paper on the Marfan Syndrome. W. A. Bates, Jr., president, presided at the meeting; William Harden, W. M. Flanagan, and Wilbur Flesch were hosts.

THE GEORGIA SOCIETY OF DERMATOLOGISTS had its organizational meeting in Atlanta, May 13, 1956, at which time Herbert S. Alden, Atlanta, was elected chairman and R. M. Reifler, Macon, secretary. Sixteen doctors attended the meeting and luncheon at the Piedmont Driving Club. It was decided to meet once a year at the time of the annual session of the M. A. G.; time and place to be set by the local dermatologists. The second meeting of the society was held Sunday, April 28, at the home of Dr. and Mrs. S. F. Rosen, 21 East 50th Street, Savannah.

PERSONALS

First District

JAMES L. ALEXANDER, Savannah, chest surgeon, was the speaker at a recent meeting of the Chatham-Savannah Tuberculosis and Health Association. LAWRENCE LEE, JR., Savannah, is president of the organization.

THOMAS A. AMBURGEY, Savannah, has been appointed medical director of the Clair Henderson Memorial Rehabilitation Center. Located at 1210 A Street, the new center is now offering services in physical rehabilitation and speech therapy. Dr. Amburgey, formerly of Hindman, Ky., is a graduate of the University

of Louisville Medical School, class of 1949. He interned and took residency training in orthopedic surgery in Oakland, Calif., Columbia, S. C., and Charleston, S. C. He began the practice of orthopedic surgery in Savannah in July 1954, and he was recently elected a diplomate of the American Board of Orthopedic Surgery.

MELVIN BERLIN, Savannah, has announced the opening of an office at 126 East Taylor Street for the general practice of medicine. Dr. Berlin is a native of Mobile, Ala.; he attended elementary schools in Savannah and graduated from Savannah High School and Duke University. He received his M.D. degree from Duke Medical School where he was secretary-treasurer of the student government and a member of the honor society. Dr. Berlin served as first chief resident at Memorial Hospital from September 1955 to February 1957 when he opened his private office.

GABRIEL D'AMATO, Savannah, was the speaker at a recent meeting of the Savannah Dental Society. He spoke on "Oral and Dental Manifestations of Anxiety."

THOMAS FREEMAN, Savannah, addressed the Savannah Kiwanis Club on the subject of geriatrics; he spoke on the increased life span in the United States and some aspects of treating older people.

THOMAS F. LAWLESS, Savannah, has been elected president of the Savannah Society of Obstetricians and Pediatricians. M. M. SCHNEIDER, Savannah, was named president-elect, and J. P. EVANS was elected secretary-treasurer.

WILLIAM H. LIPPITT and THOMAS R. FREEMAN, Savannah, are constructing a new office building at the corner of 31st and Abercorn Streets. Dr. Lippitt presently has offices at 224½ Huntingdon Street, and Dr. Freeman at 513 Whitaker Street.

W. D. LUNDQUIST, Savannah, health commissioner, was the guest speaker at a recent staff meeting of the Personal Services Club of Savannah-Chatham County Social Workers; his topic was "Mobilizing Health Resources for Disaster." Dr. Lundquist addressed the members of the Blood Donor Gallon Club of Savannah at their April

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meeting on the value and use of blood derivatives.

T. A. McGOLDRICK, Savannah, presided at the Chatham County finals of the *Morning News-American* Legion oratorical contest. Dr. McGoldrick is the father of the movement to step up interest in public speaking on the part of high school students in the 18 counties of the First District. He secured more than \$1,500 in prizes as an incentive.

JOHN MOONEY, Statesboro, has returned to his office at 31 Seibald Street after taking a postgraduate course in industrial medicine and surgery.

A panel of four doctors discussed family health at a meeting of the Jacob G. Smith Parent-Teachers Association. The panelists were EMERSON HAM, LAWRENCE SALTER, ALVIN SHURE, and R. B. GOTTSCHALK, all of Savannah.

H. C. SCHOFIELD, LAWRENCE LEE, and GABRIEL D'AMATO, all of Savannah, have been named to serve on the newly formed Medical Arts Guidance Project of the United Community Services. The purpose of the project will be to inform and interest high school students in following any one of more than 150 careers in health and allied medical fields. Co-ordinator of the project is Mrs. JOHN EMERSON PORTER, president of the Woman's Auxiliary to the Georgia Medical Society.

Second District

W. M. DYKES, Whigham, celebrated his 92nd birthday on March 27, 1957. Dr. Dykes has recently given up his active practice after practicing medicine for 65 years. He settled in Whigham 27 years ago and served as mayor for two years. Before moving to Whigham, he lived in Adairsville and Atlanta. He is a graduate of the Atlanta School of Medicine and Surgery. Dr. and Mrs. Dykes, who were married in 1889, have nine children, 21 grandchildren and nine great grandchildren.

C. W. HARWELL, Moultrie, spoke at a recent meeting of the Woman's Auxiliary to the Tift County Medical Society, held at the home of Mrs. C. S. Pittman, Tifton. Dr. Harwell talked about the acute problems of midwifery in Tift County

and gave statistics of births and pre-natal deaths in the county.

W. P. STONER, Sylvester, presented a film on medical aid to medical schools for the Sylvester Kiwanis Club in March.

ERNEST WAHL, Thomasville, spoke at the fifth annual meeting of the Northeast Georgia Chapter of the Georgia Heart Association. The meeting was held in the Continuing Education Building in Athens. Dr. Wahl is president of the Georgia Heart Association.

DAVID M. WOLFE, Albany, spoke at a recent meeting of the Mulberry P-TA on the importance of giving the Salk polio vaccine to as many children as possible before summer time comes.

Third District

M. F. ARNOLD, Hawkinsville, attended the annual meeting of the American Academy of General Practice in St. Louis in March. Dr. Arnold is president of the Georgia Academy of General Practice.

H. A. SMITH, Americus, announces the association with him in the practice of medicine of R. A. COLLINS, JR., formerly of Rochester, Minn. Dr. Collins is a native of Unadilla and a graduate of the Medical College of Georgia; he practiced in Montezuma for four years before going to Rochester where he had a fellowship in general surgery and worked on his master's degree in surgery from the University of Minnesota.

Fourth District

J. A. JOHNSON, SR., J. W. SMITH, JR., and CALVIN JACKSON, all of Manchester, attended the annual meeting of the Atlantic Coast Line Railroad Surgeons Association in Tampa, Fla., in March. Dr. Johnson has been a member of the association for 41 years; Dr. Smith and Dr. Jackson were appointed members the first of this year.

W. P. KIRKLAND, Manchester, was responsible for the program of a recent Kiwanis Club meeting in Manchester. He showed a film on "Modern Concepts of Epilepsy."

Fifth District

The Southeastern Surgical Congress Scientific Award Contest for residents was won by J. RICHARD

AMERSON, Atlanta, who presented a paper on "Acute Gastroduodenal Perforations—Study of 381 Patients" at the congress' annual meeting April 1-4, 1957, at St. Petersburg, Fla. Dr. Amerson is a resident at Grady Memorial Hospital and will begin practice in Atlanta on July 1, 1957.

ROBERT J. ANDERSON, Atlanta, Medical Director and Chief of the Communicable Disease Center, will participate in a panel discussion on "Appraisal of Mass X-Ray Surveys" at the 23rd Annual Meeting of the American College of Chest Physicians to be held at the Hotel Commodore, New York City, May 29-June 2, 1957.

M. K. BAILEY, Atlanta, was general chairman of the April 7-11 meeting of the Southeastern section of the American Urological Association. The meeting took place at the Dinkler Plaza Hotel in Atlanta. JOHN T. GODWIN, Atlanta, was a panelist for a discussion on "Cancer of the Bladder."

B. T. BEASLEY, Atlanta, and A. H. LETTON, Atlanta, were re-named secretary and treasurer, respectively, of the Southeastern Surgical Congress at their meeting in St. Petersburg, Fla.

JOE MARVIN BOSWORTH, Atlanta, has been elected a fellow of the Industrial Medical Association. The certificate was awarded at the annual meeting of the Association during the Industrial Health Conference in St. Louis, Mo., April 20-26.

ALBERT A. BRUST, Atlanta, was a speaker at the 38th Annual Session of the American College of Physicians, Boston, Mass., April 8-12, 1957. His topic was "Diagnostic and Prognostic Significance of the Vascular Retinopathies as Revealed by Serial Color Photographs."

W. E. BURDINE, Atlanta, was sworn in on February 13 as a member of the Advisory Board for the Pardon and Parole Commission of the State of Georgia.

At the meeting of the American College of Physicians held in Boston, Mass., April 12, 1957, T. STERLING CLAIBORNE, Atlanta, was elected governor of the College for Georgia. Dr. Claiborne succeeds CARTER SMITH, Atlanta, as governor. Dr. Smith has served in that

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office for the past nine years, the maximum length of time that any one person is eligible to hold this office. During the past three years, Dr. Smith has been chairman of the board of governors and a member of the board of regents of the American College of Physicians.

WILLIAM A. HOPKINS, Atlanta, was a guest speaker at a recent meeting of the District Woman's Christian Temperance Union. His subject was cigarette smoking and lung cancer.

PETER HYDRICK, Atlanta, has been appointed to represent the Georgia Academy of General Practice on the Planning Committee for the annual Daytona Obstetric and Pediatric Seminar. The seminar will begin on the second Monday in September and will probably be classified Category I by the American Academy of General Practice.

CHARLES A. LeMAISTRE, Atlanta, has been appointed chairman of the new department of preventive medicine and community health which has been set up at Emory University School of Medicine. Dr. LeMaistre was before this appointment associate professor of medicine at Emory. He is a native of Alabama and a graduate of the University of Alabama and Cornell Medical School. He interned and served as a resident at the New York Hospital-Cornell Medical Center and was on the Cornell faculty before coming to Emory in September 1954.

ARTHUR J. MERRILL, Atlanta, was one of the members of a panel discussing "Management of the Nephrotic Syndrome" at the 38th Annual Session of the American College of Physicians, Boston, April 8-12, 1957.

JAMES B. MINOR, formerly of Butler, announces the opening of his offices for the practice of internal medicine and cardiology at 406 Medical Arts Building, 384 Peachtree Street N. E., Atlanta. Dr. Minor is a native of Butler and comes to Atlanta from New York.

ROBERT P. SHINALL, Decatur, has been named Decatur's "Young Man of the Year" by the Decatur Lions Club. Dr. Shinall is president of the Decatur Kiwanis Club and practices medicine in Decatur. He is a member of the board of stewards

of the First Methodist Church, and other civic activities which resulted in his election included promotional work for the Little League, organization of the Quarterback Club to promote good sportsmanship, and organization of the Avondale Kiwanis Club.

Dr. and Mrs. EDGAR WOODY, JR., Atlanta, announce the birth of a son, James Bradsher, on April 19, 1957.

Sixth District

LEONARD H. CAMPBELL, Macon, has announced the opening of his office for the practice of pathology and clinical laboratory medicine at 548 First Street, Macon.

The *Journal* regrets to announce the death of Mrs. B. L. Helton, Sr., wife of B. L. HELTON, Sandersville, and stepmother of WILLIAM S. HELTON, also of Sandersville. Mrs. Helton died on March 15, 1957.

Seventh District

WILLIAM DILLARD, Cartersville, has been elected vice-president of the Bartow-Floyd-Polk Tuberculosis Association for the coming year. The election was held at the annual meeting in April in Rome. C. C. AVEN, Atlanta, was the guest speaker at the meeting.

JOSEPH EDWIN GRIFFITH, Marietta, has been made a fellow of the Industrial Medical Association. He was presented his certificate of fellowship at the annual meeting of the association during the Industrial Health Conference held in St. Louis, Mo., April 20-26.

FRED H. SIMONTON, Chickamauga, was elected vice-president of the American Academy of General Practice at the annual meeting held in St. Louis, Mo., in March. Dr. Simonton was the unanimous choice of the Congress of Delegates of the AAGP.

Cobb County's first pediatric clinic will be ready for occupancy in July of this year it has been announced. Three pediatricians will occupy offices in the new building behind the Kennestone Hospital. They are E. A. VAUGHAN, ROBERT CAUSEY, and ROY DUNCAN. Dr. Vaughan and Dr. Causey are presently in practice at 701 Cherokee Street, Marietta; Dr. Duncan is completing his pediatric residency in Augusta.

W. C. MITCHELL, Smyrna, announces the association with him in the practice of medicine of JOHN R. WAKEFIELD. Dr. Wakefield is a graduate of the University of Alabama and Jefferson Medical College of Philadelphia. He interned at Jefferson-Hillman Hospital, Birmingham, and had a year's surgical residency at Crawford W. Long Memorial Hospital, Atlanta, and three years in internal medicine at the Lloyd Noland Memorial Hospital, Birmingham, Ala. He has been practicing for three and a half years in the Flomaton, Ala.—Century, Fla. area.

D. LLOYD WOOD, Dalton, is taking a two-months course in surgery at New York Polyclinic Medical School in New York City. He will return to Dalton on July 1 to reopen his office on Pentz Street.

Eighth District

E. ADAMS DANEMAN, Waycross, spoke to the Waycross Lions Club recently on the prevalence of mental depression in South Georgia. He said that it is so prevalent in that section that it has become known as a "Southern disease." He said that a study made several years ago attributed the larger number of depressive cases in the South to close family and community ties which create great pressure on the individual.

FRANK MITCHELL, Brunswick, has been named a member of the Glynn County Board of Health to succeed the late ROBERT S. BURFORD.

JAMES A. WOOD, Brunswick, has been nominated to serve as governor of Rotary International's District 241, which encompasses the eastern half of Georgia. Dr. Wood, a retired pediatrician, moved to Brunswick from Macon in 1949; since that time he has served as president of the Brunswick Rotary Club and headed many committees and has built up an attendance record of 98 per cent at local meetings and has traveled abroad regularly to attend international meetings of Rotary.

Ninth District

A. FREDERICK BLOODWORTH, Gainesville, announces the opening of an office for the practice of internal medicine and diseases of the chest. A native of Gainesville,

(Personals)

he received his B. S. degree from the University of Georgia and his M.D. degree from the Medical College of Georgia. Dr. Bloodworth interned at Charity Hospital, New Orleans, and had three years residency training in internal medicine there.

GEORGE DOWDER, Dahlonge, who has practiced medicine for the past several months with J. G. WOODWARD, has reported for active duty with the U. S. Air Force at Keesler AFB, Miss. Dr. Gowder expects to return to Dahlonge when he completes his military service.

J. L. WALKER, Clarkesville, was a delegate from Georgia to the annual meeting of the American Academy of General Practice held in St. Louis in March.

Tenth District

C. I. BRYANS, JR., Augusta, announces the removal of his office to 1143 Druid Park Avenue, with practice limited to obstetrics and gynecology.

JOHN M. CALDWELL, Augusta, attended the meeting of the group for the Advancement of Psychiatry at Asbury Park, N. J., April 4th through 7th. He participated in the Committee on Cooperation with Federal Agencies of the Group.

THOMAS FINDLEY, Augusta, was a guest speaker at the convention of the Florida Medical Association held in Hollywood, Fla., May 5-8, 1957. He discussed "Diuresis and Antidiuresis" during the General Session and served as moderator for the panel on Cardiovascular Surgery at the First Scientific Assembly, May 7.

C. STEPHEN MULHERIN, Augusta, has been certified by the

American Board of Surgery. Dr. Mulherin is a 1946 graduate of the Medical College of Georgia and has been in the private practice of surgery since February 1956.

PHILIP MULHERIN, Augusta, pediatrician and father of a William Robinson Grammar School pupil, spoke on "Behavior in Children" at a recent meeting of the school's PTA.

HARRY B. O'REAR, Augusta, attended the Regional Pediatric Educational Conference at Chapel Hill, N. C. on March 29th. He also attended the meeting of the Southern Association of Medical Schools and Teaching Hospitals in Houston, Texas, from April 6th to 8th. The main discussion at this meeting was "The Use of Private Patients in Medical Education" and Dr. O'Rear was a member of this panel to discuss how this topic is concerned with undergraduate teaching.

EDGAR R. PUND, Augusta, is one of 35 members appointed to the Georgia Nuclear Advisory Commission—a group which will plan the state's future in the atomic era.

The *Journal* regrets to announce the death of Mrs. Charles Allen Talmadge, mother of SAM TALMADGE, Athens, at her home in Athens on March 20, 1957.

CORBETT H. THIGPEN, was the guest speaker for the Macon Writers' Club annual breakfast on April 13, 1957. Dr. Thigpen, a native of Macon, is co-author of the book, *The Three Faces of Eve*, which has received acclaim from critics all over the country since its early spring publication. The book, factual but not too clinical for the lay reader, is about a woman patient

of the Augusta doctors who had three distinct and separate personalities.

DAVID R. THOMAS, Augusta, was made a fellow in the American Academy of Allergy at the group's annual meeting recently in Los Angeles. He has been a member of the Academy since 1946.

V. P. SYDENSTRICKER, Augusta, has received a grant of \$16,387 for 1957 from the National Institute of Allergy and Infectious Diseases of the National Institutes of Health. The grant is renewable for three additional years for \$16,100. CLAUDE-STARR WRIGHT, Augusta, associate professor of medicine, and EDWARD GARDNER, research associate in medicine, will work with Dr. Sydenstricker.

From April 16 to 18, PERRY P. VOLPITTO, professor and chairman of the Department of Anesthesiology, Medical College of Georgia, attended the Alabama State Society of Anesthesiologists' meeting in Mobile, Ala. He presented a paper on "The Management of Anesthesia in Acute Emergencies in Children."

PERRY P. VOLPITTO, Augusta, attended the meeting of the Southern Society of Anesthesiologists in New Orleans, April 3rd to 5th. He participated in a round table luncheon panel on "Anesthesia in Patients with Emphysema," and also led a discussion on "Anesthesia in Cardiac Surgery."

HOKE WAMMOCK, Augusta, attended the Southeastern Surgical Congress which was held April 1st in St. Petersburg, Fla. At this latter meeting, he presented a paper, "Pitfalls in the Management of Cancer of the Head and Neck (Oral Cavity)."

The *JOURNAL* welcomes any and all
information for the *Information Section*. Send
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Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

The President's Address

Presented May 1, 1957, Savannah

Perspective

HAL M. DAVISON, M.D., Atlanta, Ga.

FUTURE GENERATIONS will view our age as one of barbarians. To them, we will not appear better or different from the way to us seem the warriors of Genghis Khan, who erected platforms on the bodies of their dead and wounded enemies, and thereon indulged in orgies of eating and drinking, accompanied by the cries and moans of their dying enemies. Civilization, religion, and so-called culture are failing us. The treatment of their enemies by the Japanese in the Philippines and of their prisoners of war in concentration camps, the action of the Germans in wiping out a race of people in their gas chambers and their cars of quicklime, the actions of the Soviet Union and the communists in other countries, not only against their enemies, but against their own people, and in our own country thrill murders by juveniles, gangsterism, dishonesty of officials in high office, and the immature antics of political demagogues—all of these are evidence of our lack of mental, emotional, and moral development.

It would seem that our civilization instead of saving us from all of this is, in fact, degenerating, and through this degeneration is aiding us in our progress on our path to self-destruction, not only by war but by other means. Technological development in our world has far surpassed mental, emotional, and spiritual progress; and we are using our technology to destroy ourselves.

The technology of gadgets in and out of our homes takes us away from nature and makes the natural use of muscle and brain unnecessary. From the mental standpoint, our thinking has either been geared to the development of technology or dulled by the unthoughtful use of technology created by others. Our regimented following of assembly line



HAL M. DAVISON

techniques makes it unnecessary to think. After a while we get out of the habit of thinking and resent the effort of having to do so. In our spare time, TV and murder mysteries make thoughtful conversation unnecessary, undesirable, or impossible.

So far as philosophy is concerned, we either ignore it or swallow that of the distant past without digestion and with no attempt to add anything of our own. When it comes to politics, government, and civic affairs, most of us lie to ourselves and shrug off

our personal responsibilities. Our emotional and spiritual life can utilize only that time and energy remaining after the obligations of other activities are fulfilled. Mostly we are too tired to indulge in emotional and spiritual experiences. So far as religion is concerned, the finite mentality of human beings demands dogma and theology with unassailable and unchanging creeds for us to tie to. When we have this and pay our yearly dues to the church we have satisfied our religious needs, and our souls feel no demand for an active, dynamic, spiritual life which will change to meet our needs and the needs of a changing world.

Our civilization, our religion, our culture, and our philosophy show such a lack of development because of the lack of development in each of us as individuals.

Education is a help in developing the individual, but educators are underpaid, overworked, and limited by the requirements of the head of the system. Our churches are a help, but they are limited in opportunity and by their unassailable and unchanging theology and dogma. For full development we must return to ourselves as individuals, as parents, and as world citizens. If we want a better future through development in our children, we must first develop ourselves, because they reflect us like mirrors and absorb us like sponges. So what of our perspective on the past, on the present, and on the future?

Daniel Webster died in 1852. In the latter part of his life he stated that never again would the world see such an era of culture as existed in his time. Shortly afterwards someone made the statement that the steam engine would never be a success because it would never overcome wind resistance and be able to travel more than 15 miles an hour. In 1875 the United States Commissioner of the Interior made the following statement: "New materials and new inventions have now transformed our society into its final phase, for scientific inventions can take us only a little way further." Five years later the United States Commissioner of Patents said: "We see the arrival of that period where human improvements are at an end." Certainly the statements of Daniel Webster and of these other gentlemen sound ridiculous today, but do we see any further beyond the horizon of our personal lives, our own needs and our wants, than they did in their time? Shall we look back upon the other gentlemen and Daniel Webster and think that they were mentally deficient, or shall we see them for what they were, that is, the best of their kind in their age, and then examine ourselves in the light of their statements? We find ourselves today in an age of technological development which was not even dreamed of three

decades ago. Year after year we may feel that we have reached our ultimate goals in medical treatment, and yet every year there are created new conceptions of disease and of treatment, and we can predict no end to this change.

What can we say about the development of the individual, not so much as to his physical life, but as to his mental and emotional life, and his use of his religion and his philosophy? We love, we hate, we work, we rest, we agree, we disagree and fight, we are complacent on the one hand, and restless and resentful on the other; we are impatient because we cannot settle in one day all of our problems. Is it not true that it is men who must be changed and not our problems settled? Some men say that human beings will never change, our Creator made us as we are, born with a selfish instinct of self-preservation, the pleasure instinct to make us wish to live, and other instincts to keep the race going. We use, we magnify, and we strengthen these primeval instincts as we grow older, and these men claim that without them we would not survive. They say that we can't even modify these primeval instincts. They claim that our so-called civilization and our not killing and robbing our neighbor comes not from any altruistic motive, but simply by mutual agreement that if we don't rob and kill, somebody else will not rob and kill us. In other words, if we could rob and kill and get away with it, we would do so. It is my contention that this theory is not true and that as time goes on, evolution itself, with the transmission of new developments from one generation to another, will continue through our genes to posterity. If we can't believe this, we can't believe in evolution. Heredity and environment work together by evolutionary processes to produce a better race of human beings.

It is true that we can't hurry evolution, but it is also true that we can't stop it. We can, however, by intelligent understanding of ourselves and by truthful acceptance of our problems and with proper planning, facilitate and guide the evolution of the human race to produce one beyond concept of today. We may look forward to unselfishness and aiding others instead of stealing and the creation of excessive profits in business, patriotism instead of a narrow nationalism, fellowship and brotherhood, peace and love instead of indifference, suspicion, fear, hate, and war.

But what of medicine today? Where stands the individual doctor? What is happening to the world's greatest profession, and what about our great medical institutions? Amid this great, undreamed of progress of scientific medicine there exists a fantastic nightmare of misunderstanding, lack of cooperation, antagonism, and conflict. Eighteen months ago your

president began a survey of what was happening to medicine in the United States. Most doctors, just as I was, appeared to be ignorant about these matters and not interested unless something happened to affect them personally. But everything that happens to the medical profession eventually does affect every member of our profession. We can't be indifferent to this fact. Today there are conflicts between individuals, between societies and individual members, between governing bodies and administrators of our hospitals on the one hand and hospital staffs on the other, between clinics and so-called clinics and medical societies, conflicts about insurance and about fees, and worst of all there is the conflict between county and state medical societies and our teaching institutions. Unfortunately, most of these differences stem from economic problems, which in turn influence our interpretation of our Code of Ethics.

Repeatedly we find a group of doctors, all presumably educated, honest, intelligent and ethical, sitting down together to discuss a problem. The facts in the case remain the same, but part of the group of doctors will interpret these facts in one way and the other part will interpret them in exactly the opposite way. Now it is well to have people differ from us. If we are not intelligent we will lose our perspective through anger, resentment, and with it goes our power of reasoning. If we are intelligent, we will reason and analyze the motivation which made others differ from us, and thereby we shall either see our own faults and correct them, or we shall be strengthened in our vision of the facts in the case. Thus our education and our growth can be continuous.

It is evident that there is no such thing as a perfect, complete human being. Each of us has the power of vision, but, unfortunately, this vision is shaded by our ignorance, our prejudices, and by our selfishness. How then shall we see truth and facts? When we are confronted with the spectacle of people such as mentioned above, arriving at opposite and conflicting conclusions, shall we succumb to cynicism; is there no truth in the world but only a human being's interpretation of facts? So it has been for all time, so it is, and so shall it be, but what shall you and I do about it within ourselves? What do we propose to do about the future? We say we have faith in the future. Yes, so we have, but so many people who have faith take refuge in that faith and do nothing about the future. They have faith only in something or somebody outside of themselves.

Let us in addition to this type of faith develop a faith in ourselves and faith in our continued development, faith in our power to develop in the future.

We need to produce the proper perspective on ourselves, on others, on the past, on the present, and on the future.

Mark Twain once said, "There would be no progress were it not for a lot of funerals." The truth in this statement helps to give us the proper perspective on ourselves. Few of us are important, and yet the world is made up of a lot of unimportant people, each contributing his own bit to the present and to the development of the future.

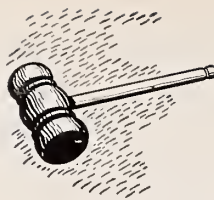
Regardless of what happens we must hold fast to those basic principles which our medical organizations have established and for which they have fought for so long. We must recognize and evaluate accurately the problems and the needs of our institutions, but we must not surrender to expediency. However, we must not blind ourselves to the extent that we cannot accept the necessity for changing our concepts. Medical needs must be met, and if we don't meet them someone else will and should. We can't hold to an unchanging past; we must meet the demands of the present and have vision with which to foresee the needs of the future. Only with this type of perspective can medicine survive.

A few years ago my brother, T. C. Davison, M.D., wrote an article entitled "The Romance of Medicine" in which he outlined the development of medicine to the present. Romance and adventure in reality mean something new and something that gives us new experiences of an exciting nature. There will always be romance and adventure in medicine in which we all may share. The fires of the pioneering spirit will never be quenched. Those bold ones who have the compulsion for seeking and the brains to seek with shall always be pushing on to new frontiers of discovery. Those of us to whom it has not been given to create, may comprehend what others have discovered, and have the privilege of sharing it with our patients. Pioneering brings opportunity to us all.

So time marches on and medicine marches with it, and each of us may march with medicine. Let us not be disappointed in ourselves or in others, or in medicine as a whole, because of these differences and conflicts. Let us keep our perspective clear. Then we shall not view the past with derision and belittle it. We shall be grateful for our present progress and look with hope toward the future. May we view the past in relation to our present and interpret the future with what we learn from our past.

By these means we shall do away with antagonism and resentment against our fellows and against situations which annoy us. We shall continue to develop ourselves and medicine as a whole and be willing to keep working to solve these problems which shall continue to arise, and without which there would be no progress.

president's letter



THIS is my first opportunity to write a president's letter. Public opinion has it that the letter is seldom read—so apparently there is something wrong somewhere. Maybe it is like the Negro's sermon—too long. I still agree that more people are converted in the first five minutes of a sermon than in the last hour and a half.

The Medical Association of Georgia is your organization—it is no better than you are—the officers are your representatives to act as a buffer for you—to work in your interests—and it should behoove each and every one of you to give it your undivided attention, for your professional organization is basic in your professional life. There are many influences working to undermine the present way of American life and the practice of medicine, and unless, we stop! look! and listen! and act!, the practice of medicine will be taken over by these same sinister forces.

We are beginning a new year—with new officers and new committees and it is my sincere hope that we will all work together for the good of the organization and the betterment of our patients.

The M. A. G. office, its efficient staff headed by Mr. Krueger and Mr. Kiser and all of your officers are behind you one hundred percent and stand ready to aid and abet you, so let's all get behind each other, and behind our organization, and many of our problems will vanish. I expect to give you a brief resume each month of the problems that we encounter, for I can't cope with them alone—neither can Council—it is going to take the combined efforts of each and every member. I earnestly ask you to write me your suggestions, complaints, and your recommendations. We want constructive criticism that will do the organization good but not criticism that favors a personal few. As the old Negro said when the clock struck 13, "It's later than I'z ever knowed it to be."

Bruce Schaefer

OFFICIAL PROCEEDINGS

***103rd Annual Session**

of the

MEDICAL ASSOCIATION OF GEORGIA

Savannah, April 28-May 1, 1957

* Last year it was brought to the attention of the House of Delegates that the numbering of annual sessions was inconsistent with

the actual number of sessions. To rectify this mistake, this session, instead of being the 107th, is the second 103rd.

First Session, House of Delegates

Sunday, April 28, 1957

THE FIRST SESSION of the House of Delegates of the Medical Association of Georgia was called to order by Speaker Thomas W. Goodwin, Augusta, at 5:05 p.m., April 28, 1957, in the Ballroom, Hotel DeSoto, Savannah, Georgia.

Speaker Goodwin presented the invocation.

Eustace A. Allen, Atlanta, Chairman of the House Credentials Committee, reported that more than 40 of the registered members of the House were present, and Speaker Goodwin declared a quorum present and accounted for, and the House in Session.

Attendance

In compilation of attendance taken from the official roll, 44 county medical societies were represented by their duly elected delegates. Thirty county medical societies were not represented at this session. Of a total of 136 delegates from their respective county medical societies, the official roll showed 94 delegates present at this meeting.

BARTOW: William B. Quillian; BIBB: J. D. Applewhite, Edwin R. Watson, W. W. Baxley, E. C. McMillan; BULLOCH-CANDLER-EVANS: L. H. Griffin; BURKE: Charles G. Green; CARROLL-DOUGLAS-HARALSON: Phil C. Astin, J. I. Vansant; CHEROKEE-PICKENS: C. J. Roper; CLAYTON FAYETTE: Wells Ridley; COBB: M. M. Hagood, W. C. Mitchell, E. P. Inglis, Jr.; COFFEE: Sage Harper; COLQUITT: John P. Tucker; DECATUR SEMINOLE: Charles G. Bellville; DeKALB: W. A. Mendenhall, Floyd R. Sanders, George L. Mitchell; DOUGHERTY: Charles G. Lamb, Glenn E. Seymour; ELBERT: J. B. O'Neal, III; EMANUEL: R. J. Moye; FLINT: Woodrow Goss; FLOYD: S. D. Smith, Ralph N. Johnson, A. V. Gafford; FULTON: J. Frank Walker, Helen Bellhouse, Thomas J. Anderson, Rives Chalmers, August B. Turner, Dan Y. Sage, Lester Rumble, Jr., Mason I. Lowance, Don F. Cathcart, Cyrus W. Strickler, Jack C. Norris, Richard Wilson, Amey Chappell, Thomas Guffin, V. E. Powell, C. E. Rushin, A. J. Crumbley, Tully T. Blalock, H. Bagley Benson, Linton Bishop, Wm. C. Coles, Scott Tarplee; GEORGIA MEDICAL SOCIETY: John L. Elliott, W. H. Fulmer, Lee Howard, Jr., Ruskin King, T. A. Peterson, David Robinson; GLYNN: C. A. Wilson, Jr., Joseph B. Mercer; GORDON: Lewis R. Lang; HABERSHAM: F. O. Garrison; HALL: Rafe Banks, Jr., P. K. Dixon; JENKINS: A. P. Mulkey; LAURENS: William A. Dodd; CRAWFORD W. LONG: James A. Green, R. H. Randolph; McDUFFIE: A. G. LeRoy; MERIWETHER-HARRIS: W. P. Kirkland; MUSCOGEE: Roy L. Gibson, Frank B. Schley, Charles R. Smith; NEWTON: H. E. Griggs; OCMULGEE: M. F. Arnold; PEACH BELT: H. E. Weems; RICHMOND: W. A. Fuller, David R. Thomas, Jr., George W. Wright, R. C. McGahee, A. J. Waters, J. L. Chandler; SOUTH GEORGIA: F. G. Eldridge, A. G. Little, Jr.; SPALDING: A. S. Fitzhugh, Virgil B. Williams; TELFAIR: F. R. Mann, Sr.; THOMAS-BROOKS: L. M. Shealy; TROUP: C. T. Cowart, H. H. Hammett, Jr.; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: Fred H. Simonton; WALTON: Ralph Wenzel; WARE: W. L. Pomeroy, Leo Smith; WARREN: H. B. Cason; WAYNE: J. W. Yeomans.

County medical societies not represented at this Session of the House of Delegates were as follows:

ALTAMAHA, BALDWIN, BEN HILL-IRWIN, BLUE RIDGE, CHATTAHOOCHEE, CHATTOOGA, COWETA, FRANKLIN-HART, GRADY, JACKSON-BARROW, JASPER, JEFFERSON, LAMAR, MITCHELL, OCONEE, POLK, RABUN, RANDOLPH, SCREVEN, SOUTHEAST GEORGIA, SOUTHWEST GEORGIA, STEPHENS, SUMTER, TAYLOR, TRI-COUNTY, WASHINGTON, WHITFIELD, WILKES, WORTH.

Ex-officio members of the House of Delegates in attendance were:

Spencer A. Kirkland, Eustace A. Allen, C. H. Richardson, Sr., AMA Delegates; Hal M. Davison, President; W. Bruce Schaefer, President-Elect; H. Dawson Allen, Immediate Past President; Carl C. Aven, First Vice-President; Bernard P. Wolff, Second Vice-President; David Henry Poer, Secretary-Treasurer; Thomas W. Goodwin, Speaker of the House; Lee Howard, Sr., First District Councilor; George R. Dillinger, Second District Councilor; W. G. Elliott, Third District Councilor; Luther H. Wolff, Third District Vice-Councilor; J. G. McDaniel, Fifth District Councilor; Henry H. Tift, Sixth District Councilor; George H. Alexander, Sixth District Vice-Councilor; Ralph W. Fowler, Seventh District Vice-Councilor; Harry L. Cheves, Tenth District Councilor; C. F. Holton, Past President; Charles R. Andrews, Ninth District Councilor; Wm. R. Dancy, Past President; Wm. P. Harbin, Jr., Past President; A. M. Phillips, Past President; Ralph H. Chaney, Past President; W. F. Reavis, Past President; C. J. McLoughlin, Chairman, Public Service Committee; Ted F. Leigh, Chairman, Scientific Exhibits; and Mr. Milton D. Krueger, Executive Secretary.

Reference Committees

Speaker Goodwin appointed the following House of Delegates reference committees:

REFERENCE COMMITTEE NO. 1: David R. Thomas, Jr., Augusta, Chairman; John B. O'Neal, Elberton, Vice-Chairman; Virgil B. Williams, Griffin, Secretary; Floyd R. Sanders, Decatur; William B. Quillian, Cartersville; Leo Smith, Waycross; Ralph Johnson, Rome; F. O. Garrison, Demorest; Edwin Watson, Macon.

REFERENCE COMMITTEE NO. 2: T. A. Sappington, Thomaston, Chairman; Don F. Cathcart, Atlanta, Vice-Chairman; A. V. Gafford, Rome, Secretary; William Henry Fulmer, Savannah; J. D. Applewhite, Macon; M. F. Arnold, Hawkinsville; Joseph B. Mercer, Brunswick; H. B. Cason, Warrenton; Ralph H. Chaney, Augusta; S. A. Fitzhugh, Griffin.

REFERENCE COMMITTEE NO. 3: Rafe Banks, Gainesville, Chairman; Frank B. Schley, Columbus, Vice-Chairman; James A. Green, Athens, Secretary; J. Frank Walker, Atlanta; A. J. Waters, Augusta; Glenn E. Seymour, Albany; A. G. LeRoy, Thomson; C. F. Holton, Savannah; C. G. Green, Waynesboro; G. L. Mitchell, Decatur.

REFERENCE COMMITTEE NO. 4: E. C. McMillan, Jr., Macon, Chairman; Linton H. Bishop, Jr., Atlanta, Vice-Chairman; Charles T. Cowart, LaGrange, Secretary; W. L. Pomeroy, Waycross; James H. Byram, Atlanta; T. A. Peterson, Savannah; Paul L. Bradley, Dalton; James W. Yeomans, Jesup; R. J. Moye, Swainsboro; William P. Harbin, Rome.

REFERENCE COMMITTEE NO. 5: H. G. Davis, Jr., Sylvester, Chairman; C. J. Roper, Jasper, Vice-Chairman;

H. E. Weems, Perry, Secretary; Roy L. Gibson, Columbus; Frank Mann, Sr., McRae; George H. Wright, Augusta; A. M. Phillips, Macon.

Credentials Committee

Speaker Goodwin announced the prior appointments of the House of Delegates Credentials Committee as follows:

Eustace A. Allen, Atlanta, Chairman; W. W. Baxley, Macon, and John L. Elliott, Savannah.

Tellers Committee

Speaker Goodwin appointed the following members to the Tellers Committee:

Ralph Chaney, Augusta, Chairman; William R. Dancy, Savannah, and Grady N. Coker, Canton.

Approval of 1956 Minutes

To expedite the reading and adoption of the minutes of the 106th Annual Session of the House of Delegates of the Medical Association of Georgia, May 13 and May 15, 1956, in the Academy of Medicine auditorium, Atlanta, the chair entertained a motion that these minutes, as published in the June 1956 issue of the *Journal of the Medical Association of Georgia*, be approved. It was so moved (Cathcart-Dancy). The motion was approved.

Memorial Service

Speaker Goodwin led the Memorial Service as follows: "It is fitting that before assuming the responsibility of charting the course of our Association, we now pay tribute to our forebears who devoted their lives and skill to the advancement of our profession. Since this gavel adjourned our 1956 Session, many members of the Medical Association of Georgia have been called from their labors by the Great Physician. May I suggest at this hour that we well appreciate and pay sincere tribute to their service and memory which will forever remain our heritage. I would ask that you remain standing while I offer a prayer and call the names of our departed colleagues . . ."

WILLIAM POPE BAKER, Atlanta, July 11, 1956
CECIL HOWELL BLACKBURN, Conyers, June 4, 1956
LEO J. BLUM, JR., Warner Robins, December 8, 1956
CHARLES E. BOYNTON, Atlanta, November 22, 1956
WILLIAM HENRY BROOKS, Monticello, Utah, May 4, 1956
ROBERT STALLINGS BURFORD, Brunswick, January 2, 1957
STEVAN M. CARROLL, JR., Marietta, January 24, 1957
JAMES MOBLEY COMBS, Atlanta, October 15, 1956
WILLIAM BARRON CRAWFORD, SR., Savannah, April 1, 1956
FRANK C. DANIEL, Pavo, April 12, 1956
VIRGIL CLYDE DAVES, Vienna, July 12, 1956
HOWARD CLIFTON DERRICK, SR., Oglethorpe, June 8, 1956
ROGER W. DICKSON, Atlanta, February 21, 1957
WILLIAM BEERS DOVE, Macon, December 12, 1956
CHARLES HALL FARMER, Macon, June 23, 1956
RUPERT H. FIKE, Moultrie, October 29, 1956
JOHN FUNKE, Atlanta, December 1, 1956
W. N. FRAYSER, Macon, December 17, 1956
JOHN LUCIUS GARRARD, Rome, December 4, 1956
I. MALCOLM GIBSON, Valdosta, March 31, 1957
THOMAS H. HALL, Macon, March 5, 1957
R. E. HAMILTON, Douglasville, March 30, 1957
LOUIS M. HAWKINS, Blackshear, November 16, 1956
HOWELL PARKS HOLBROOK, Tucker, November 13, 1956
ISAAC BELL HOWARD, Williamson, August 10, 1956
JAMES NATHANIEL ISLER, Meigs, October 25, 1956
JAMES SWAYNE JOLLEY, Homer, December 7, 1956
HUGH M. LOKEY, Atlanta, February 23, 1957
GEORGE Y. MASSENBURG, SR., Macon, September 1, 1956
J. D. McELROY, Atlanta, April 26, 1957
ROY W. McGEE, Atlanta, November 29, 1956

R. M. MOORE, Atlanta, January 21, 1957
G. S. MURRAY, Columbus, March 31, 1957
C. T. NELLANS, Roswell, May 25, 1956
J. L. NEVIL, Metter, April 6, 1957
GEORGE TRACY OLMSTEAD, Savannah, November 29, 1956
OSCAR W. ROBERTS, SR., Carrollton, December 19, 1956
JAMES VIRGIL ROGERS, SR., Cairo, August 25, 1956
AMOS C. SMITH, Elberton, March 30, 1957
FLETCHER ADRIAN SMITH, Elberton, July 14, 1956
INMAN PARKER SMITH, Rome, October 5, 1956
LEIGHTON ALEXANDER SMITH, Quitman, May 7, 1956
T. W. STEWART, Lithonia, August 13, 1956
J. T. STOVALL, Jefferson, January 19, 1957
JAMES R. WHITLEY, Winder, January 5, 1957
C. O. WILLIAMS, West Point, March 22, 1957
PIERCE LEE WILLIAMS, Cordele, July 9, 1956
J. D. ZACHARY, Gray, April 6, 1957

Annual Reports

Speaker Goodwin announced the Annual Reports as the next item of business. (A cross reference of the reports of officers, committee chairmen, addendums, and resolutions introduced at this session are listed below with the reference committee to which the report was referred. The full report and action by the reference committee and the House of Delegates are listed under the proceedings of the Second Session of the House of Delegates. See pages 248-306.)

REPORTS OF OFFICERS

President—Hal M. Davison, Atlanta—Reference Committee No. 1—See page 248
President-Elect—W. Bruce Schaefer, Toccoa—Reference Committee No. 1—See page 250
Immediate Past President—H. Dawson Allen, Jr., Milledgeville—Reference Committee No. 1—See page 251
First Vice-President—Carl C. Aven, Marietta—Reference Committee No. 4—See page 275
Second Vice-President—Bernard P. Wolff, Atlanta—Reference Committee No. 4—See page 275
Secretary—David Henry Poer, Atlanta—Reference Committee No. 3—See page 271
Treasurer—David Henry Poer, Atlanta—Reference Committee No. 3—See page 272
Speaker of the House—Thomas W. Goodwin, Augusta—Reference Committee No. 2—See page 256
Vice-Speaker of the House—Fred H. Simonton, Chickamauga—Reference Committee No. 2—See page 256
AMA Delegates—C. H. Richardson, Sr., Macon; Eustace A. Allen, Atlanta, and Spencer A. Kirkland, Atlanta—Reference Committee No. 2—See page 256
First District Councilor—Lee Howard, Sr., Savannah—Reference Committee No. 5—See page 299
First District Vice-Councilor—Charles T. Brown, Guyton—Reference Committee No. 5—See page 300
Second District Councilor—George R. Dillinger, Thomasville—Reference Committee No. 5—See page 300
Second District Vice-Councilor—J. Z. McDaniel, Albany—No report.
Third District Councilor—W. G. Elliott, Cuthbert—Reference Committee No. 5—See page 300
Third District Vice-Councilor—Luther H. Wolff, Columbus—Reference Committee No. 5—See page 300
Fourth District Councilor—J. W. Chambers, LaGrange—Reference Committee No. 1—See page 251
Fourth District Vice-Councilor—C. B. Palmer, Covington—No report.
Fifth District Councilor—J. G. McDaniel, Atlanta—Reference Committee No. 1—See page 251
Fifth District Vice-Councilor—Charles S. Jones, Atlanta—Reference Committee No. 1—See page 255
Sixth District Councilor—Henry H. Tift, Macon—Reference Committee No. 1—See page 253
Sixth District Vice-Councilor—George H. Alexander, Forsyth—Reference Committee No. 1—See page 253
Seventh District Councilor—D. Lloyd Wood, Dalton—Reference Committee No. 3—See page 267
Seventh District Vice-Councilor—Ralph W. Fowler, Marietta—Reference Committee No. 3—See page 267
Eighth District Councilor—F. G. Eldridge, Valdosta—Reference Committee No. 3—See page 268

Eighth District Vice-Councilor—J. M. Hicks, Brunswick—Reference Committee No. 3—No report.
 Ninth District Councilor—Charles R. Andrews, Canton—Reference Committee No. 3—See page 268
 Tenth District Councilor—Harry L. Cheves, Union Point—Reference Committee No. 2—See page 259
 Tenth District Vice-Councilor—J. Victor Roule, Augusta—No report.

REPORT OF COUNCIL

Council—George R. Dillinger, Thomasville—Reference Committee No. 4—See page 276

REPORTS OF COMMITTEES

Legislation—M. F. Simmons, Decatur, Chairman—Reference Committee No. 2—See page 259
 Medical Education—R. C. McGahee, Augusta, Chairman—Reference Committee No. 4—See page 292
 Medical Defense—W. L. Pomeroy, Waycross, Chairman—Reference Committee No. 5—See page 301
 Professional Conduct—A. M. Phillips, Macon, Chairman—Reference Committee No. 1—See page 250
 History and Vital Statistics—J. Calvin Weaver, Atlanta, Chairman—Reference Committee No. 1—See page 253
 Public Health—T. A. Sappington, Thomaston, Chairman—Reference Committee No. 3—See page 268
 Maternal and Infant Welfare—Charles M. Mulherin, Augusta, Chairman—Reference Committee No. 3—See page 269
 Rural Health—J. Lee Walker, Clarkesville, Chairman—Reference Committee No. 5—See page 301
 Industrial Health—Duncan Shepard, Atlanta, Chairman—Reference Committee No. 1—See page 254
 Public Service—Chris J. McLoughlin, Atlanta, Chairman—Reference Committee No. 5—See page 303
 Cancer—J. Elliott Scarborough, Atlanta, Chairman—Reference Committee No. 5—See page 304
 Insurance and Economics—David R. Thomas, Jr., Augusta, Chairman—Reference Committee No. 2—See page 260
 Veterans Affairs—Hartwell Joiner, Gainesville, Chairman—Reference Committee No. 5—See page 304
 Constitution and By-Laws—Thomas W. Goodwin, Augusta, Chairman—Reference Committee No. 2—See page 261
 Scientific Exhibit Awards—Ted F. Leigh, Atlanta, Chairman—Reference Committee No. 5—See page 304
 Advisory to Woman's Auxiliary—Edgar M. Dunstan, Atlanta, Chairman—Reference Committee No. 2—See page 261
 Hospital Relations—Milford B. Hatcher, Macon, Chairman—Reference Committee No. 5—See page 305
 Geriatrics—Edgar Woody, Jr., Atlanta, Chairman—Reference Committee No. 3—See page 270
 Crawford W. Long Memorial—Lester Rumble, Jr., Atlanta, Chairman—Reference Committee No. 2—See page 261
 Mental Health—Rives Chalmers, Atlanta, Chairman—Reference Committee No. 1—See page 251
 Medical Civil Preparedness—Edgar M. Dunstan, Atlanta, Chairman—Reference Committee No. 3—See page 270
 American Medical Education Foundation—Ben K. Looper, Canton, Chairman—Reference Committee No. 2—See page 261
 Blood Banks—Warren B. Matthews, Marietta, Chairman—Reference Committee No. 4—No report.
 Abner W. Calhoun Lectureship—Glenville Giddings, Atlanta, Chairman—Reference Committee No. 4—See page 296
 Advisory to Crippled Children—J. C. Hughston, Columbus, Chairman—Reference Committee No. 4—See page 296
 Advisory to Selective Service—David Henry Poer, Chairman, Atlanta—Reference Committee No. 1—See page 254

ALLIED REPORTS

Report of the Headquarters Office—Mr. Milton Krueger and Mr. John Kiser, Atlanta—Reference Committee No. 3—See page 270
 Report of the *Journal*—Edgar Woody, Jr., and Miss Frances H. Porcher, Atlanta—Reference Committee No. 2—See page 262
 Woman's Auxiliary to the MAG—Mrs. Walker L. Curtis, President, College Park—Reference Committee No. 2—See page 263
 Better Health Council—Mrs. W. Bruce Schaefer, President, Toccoa—Reference Committee No. 3—No report.

General Practitioner of the Year Award

Speaker Goodwin called on Chairman of Council George R. Dillinger to present nominations received by the Headquarters Office for the 1957 "Georgia General Practitioner of the Year Award." He presented in nomination the following names: G. L. Broadrick, Dalton; J. C. Stone, Doerun; and Frank B. Pickett, Ty Ty. Speaker Goodwin called for nominations from the floor, and there being none he requested that a vote by secret ballot be taken by the Tellers Committee. Tellers Committee announced the following result: Frank B. Pickett of Ty Ty, named "General Practitioner of the Year."

Hardman Award

Speaker Goodwin called on W. G. Elliott of Cuthbert, Chairman of the Council Hardman Award Committee, to present nominations received by the Council for this high honor. Dr. Elliott presented in nomination the following members; E. P. Inglis, Marietta, and J. W. Chambers, LaGrange. Speaker Goodwin called for nominations from the floor and recognized Jack C. Norris, Atlanta. Dr. Norris nominated Murdock Equen, Atlanta, and this nomination was duly seconded. Speaker Goodwin called for further nominations, and, there being none, it was moved that nominations be closed. A secret ballot was taken and the Tellers Committee announced the following result: J. W. Chambers, LaGrange, named as recipient of the Hardman Award.

Addendums to Reports

Council Report, Addendum No. 1—George R. Dillinger, Thomasville, Chairman—Reference Committee No. 4—See page 296
 Medical Education Committee, Addendum No. 2—Charles S. Stone, Atlanta, Chairman—Reference Committee No. 4—See page 294
 Professional Conduct Committee, Addendum No. 3—A. M. Phillips, Macon, Chairman—Reference Committee No. 1—See page 250
 Rural Health Committee, Addendum No. 4—J. Lee Walker, Clarkesville, Chairman—Reference Committee No. 5—See page 305
 Crippled Children Committee, Addendum No. 5—J. C. Hughston, Columbus, Chairman—Reference Committee No. 4—See page 296.
 Selective Service Committee, Addendum No. 6—David Henry Poer, Atlanta, Chairman—Reference Committee No. 1—See page 255
 Medical Civil Preparedness, Addendum No. 7—Edgar M. Dunstan, Atlanta, Chairman—Reference Committee No. 3—See page 274
 Medical Education Committee Second Addendum, No. 8—Charles F. Stone, Atlanta, Chairman—Reference Committee No. 4—See page 295

The Chair called for additional addendum reports, and there being none, the Chair called for any other items of unfinished business. As no more unfinished business was introduced, the Chair called for new business.

Resolutions

Resolution No. 1—Radiology—William C. Coles, Atlanta—Reference Committee No. 2—See page 264

Resolution No. 2—Hospitalization of the Mentally Ill—Rives Chalmers, Atlanta—Reference Committee No. 1—See page 252
 Resolution No. 3—Anesthesiology, Radiology, Pathology Inclusion in Medicare—J. Frank Walker, Atlanta—Reference Committee No. 2—See page 264
 Resolution No. 4—Federal Medical Expenditures—H. Bagley Benson, Atlanta—Reference Committee No. 5—See page 305
 Resolution No. 5—Hospitalization of Patients with Alcoholism—Scott L. Tarplee, Atlanta—Reference Committee No. 3—See page 274
 Resolution No. 6—VA Hospital Construction—Tully T. Blalock, Atlanta—Reference Committee No. 5—See page 305
 Resolution No. 7—Nursing Shortage—T. J. Anderson, Atlanta—Reference Committee No. 3—See page 274
 Resolution No. 8—Blue Shield-Blue Cross Plan—Thomas-Brooks Medical Society—Reference Committee No. 2—See page 265
 Resolution No. 9—Hospitalization of the Mentally Ill—Bibb County Medical Society—Reference Committee No. 1—See page 253
 Resolution No. 10—Fund for Students to SAMA Convention—R. C. McGahee, Augusta—Reference Committee No. 3—See page 275
 Resolution No. 11—M. D.-Social Security—E. C. McMillan, Macon—Reference Committee No. 4—See page 298
 Resolution No. 13—Practice of Medicine—W. A. Fuller, Augusta—Reference Committee No. 2—See page 265

Resolution No. 14—Revised Waters Resolution—A. Jack Waters, Augusta—Reference Committee No. 4—See page 287
 Resolution No. 15—Standardization of Health Insurance Forms—John B. O'Neal, Elberton—Reference Committee No. 2—See page 265
 Resolution No. 16—A. M. E. F.—George H. Alexander, Forsyth—Reference Committee No. 2—See page 265
 Resolution No. 17—Standardization of Insurance Forms—Joseph B. Mercer, Brunswick—Reference Committee No. 2—See page 265
 Resolution No. 18—Social Security—Luther H. Wolff, Columbus—Reference Committee No. 4—See page 299
 Resolution No. 19—Medicare Program—Frank B. Schley, Columbus—Reference Committee No. 2—See page 266
 Resolution No. 20—Tax Deductions—John B. O'Neal, Elberton—Reference Committee No. 2—See page 266
 Resolution No. 21—Medicare—Charles R. Andrews, Canton—Reference Committee No. 2—See page 266
 Resolution No. 22—Recognition of David Henry Poer—C. F. Holton, Savannah—Reference Committee No. 2—See page 267

Speaker Goodwin called for any other items of new business and there being none, he made announcements concerning functions in connection with the *103rd Annual Session. On motion, the meeting was recessed at 6:25 p.m.

General Business Session

Monday, April 29, 1957

THE GENERAL BUSINESS Session of the 103rd Annual Session of the Medical Association of Georgia was called to order by President Hal M. Davison, Atlanta, at 11:50 a.m., in the Ballroom of the Hotel DeSoto, Savannah, Georgia.

President Davison called on Murdock Equen, Atlanta, to introduce the speaker for the Equen Memorial Lectureship, Albert C. Fuerstenberg, Ann Arbor, Michigan, who spoke on the subject "A Look to the Future."

Upon completion of this talk, President Davison relinquished the gavel to First Vice-president Carl C. Aven, Marietta.

President Hal M. Davison delivered the President's Address, entitled "Perspective," and following this, Dr. Davison again assumed the duties of presiding officer.

President Davison called for nominations for Association officers and appointed a Tellers Committee with W. L. Pomeroy, Waycross, as chairman.

The president then called for nominations from the floor for the following offices: president-elect; first vice-president; second vice-president; secretary; AMA delegate (term beginning 1, 1958); AMA alternate delegate (term beginning January 1, 1958); councilor, Ninth District (term expires 1960); vice-councilor, Ninth District (term expires 1960); councilor, Tenth District (term expires 1960); vice-councilor, Tenth District (term expires 1960).

Nominations for these offices were as follows:

President-Elect—Lee Howard, Sr., Savannah, nominated

by C. F. Holton, Savannah; seconded by Allen H. Bunce, Atlanta, and George R. Dillinger, Thomasville.

First Vice-President—T. A. Peterson, Savannah, nominated by Walter Brown, Savannah, and duly seconded.

Second Vice-President—Hugh J. Bickerstaff, Columbus, nominated by Frank Schley, Columbus, and duly seconded.

Secretary—Chris J. McLoughlin, Atlanta, nominated by James C. Metts, Savannah, seconded by Eustace A. Allen, Atlanta, and David Henry Poer, Atlanta.

AMA Delegate—Charles H. Richardson, Macon, nominated by Allen H. Bunce, Atlanta; seconded by W. A. Selman, Atlanta, and Thomas W. Goodwin, Augusta.

Grady N. Coker, Canton, nominated by C. J. Roper, Jasper, seconded by Roy Gibson, Columbus, and Charles Wall, Thomasville.

AMA Alternate Delegate—J. W. Chambers, LaGrange, nominated by H. L. Cheves, Union Point, and duly seconded.

Ninth District Councilor—Charles R. Andrews, Canton.

Ninth District Vice-Councilor—Paul Scoggins, Commerce.

Tenth District Councilor—Addison W. Simpson, Jr., Washington.

Tenth District Vice-Councilor—David R. Thomas, Jr., Augusta.

There being no opposition to the nominations for all of the offices except AMA Delegate, nominations for those offices were tantamount to election, and the secretary was instructed to cast a unanimous ballot on behalf of the membership for each of these nominees. The chairman of the Tellers Committee, W. L. Pomeroy, then announced election hours with the voting confined to the AMA Delegate contest.

On motion by David Henry Poer, Atlanta, seconded by Dan Y. Sage, it was moved that C. L. Ayers of Toccoa be elected to the office of Honorary Delegate to the AMA. This motion was approved.

There being no further business, this general session was adjourned at 1:30 p.m.

Second Session, House of Delegates

(Recessed)

Tuesday, April 30, 1957

THE SECOND SESSION (Recessed) of the House of Delegates of the Medical Association of Georgia was called to order by Vice-Speaker Fred H. Simonton, Chickamauga, at 2:40 p.m., April 30, 1957, in the Ballroom of the Hotel DeSoto, Savannah.

Vice-Speaker Simonton called on Credentials Committee Chairman Eustace A. Allen, who reported a quorum present, and also later reported the following attendance.

Attendance

In a compilation of attendance taken from the official roll, 45 county medical societies were represented by their duly elected delegates. Twenty-nine county medical societies had no representatives at the second session. Of a total of 136 delegates from the respective county medical societies, the official roll showed 92 delegates present at this session.

BALDWIN: Wallace Gibson; BIBB: J. D. Applewhite, Edwin R. Watson, W. W. Baxley, E. C. McMillan; BURKE: J. M. Byne, Jr.; CARROLL-DOUGLAS-HARALSON: Phil C. Astin, J. I. Vansant; COBB: E. P. Inglis, Jr.; COFFEE: Sage Harper; COLQUITT: John P. Tucker; DECATUR-SEMINOLE: Charles G. Bellville; DeKALB: W. A. Mendenhall, Floyd R. Sanders, George L. Mitchell; DOUGHERTY: Charles G. Lamb, Glenn E. Seymour; EMANUEL: R. J. Moye; FLINT: Woodrow W. Goss; FLOYD: Ralph N. Johnson, A. V. Gafford; FULTON: J. Frank Walker, Helen W. Bellhouse, Thomas J. Anderson, August B. Turner, Dan Y. Sage, Lester Rumble, Jr., Mason I. Lowance, Don F. Cathcart, Cyrus W. Strickler, A. O. Linch, Richard Wilson, Amey Chappell, Thomas Guffin, Vernon E. Powell, C. E. Rushin, A. J. Crumbley, Tully T. Blalock, H. Bagley Benson, Linton H. Bishop, Jr., William C. Coles, Scott L. Tarplee; GEORGIA MEDICAL SOCIETY: John L. Elliott, W. H. Fulmer, Ruskin King, David Robinson; GLYNN: C. A. Wilson, Jr., Joseph B. Mercer; GORDON: Lewis R. Lang; HABERSHAM: F. O. Garrison; HALL: Rafe Banks, Jr., P. K. Dixon; JEFFERSON: C. R. Williams; JENKINS: A. P. Mulkey; LAURENS: William A. Dodd; CRAWFORD W. LONG: James A. Green, R. H. Randolph; McDUFFIE: A. G. LeRoy; MUSCOGEE: Roy L. Gibson, Frank B. Schley, Charles R. Smith, Luther H. Wolff; NEWTON: H. E. Griggs; OCMULGEE: M. F. Arnold; OCONEE VALLEY: C. S. Jernigan; PEACH BELT: Frank Vinson; RICHMOND: Thomas W. Goodwin, W. A. Fuller, David R. Thomas, George W. Wright, R. C. McGahee, Nathan M. DeVaughn, A. J. Waters, F. N. Harrison; SOUTH GEORGIA: F. G. Eldridge, A. G. Little, Jr.; SOUTHEAST GEORGIA: J. W. Palmer; SPALDING: A. S. Fitzhugh, Virgil B. Williams; STEPHENS: Robert E. Shiflet; TELFAIR: F. R. Mann, Sr.; THOMAS-BROOKS: L. M. Shealy; TROUP: H. H. Hammett, Jr.; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: Fred H. Simonton; WARE: W. L. Pomeroy, Leo Smith; WARREN: H. B. Cason; WASHINGTON: W. S. Helton; WAYNE: J. W. Yeomans; WHITFIELD: Paul L. Bradley; WORTH: H. G. Davis, Jr.

County medical societies not represented at this Second Session of the House of Delegates are as follows:

ALTAMAHA, BARTOW, BEN HILL-IRWIN, BLUE RIDGE, BULLOCH-CANDLER-EVANS, CHATTAHOOCHEE, CHATTOOGA, CHEROKEE-PICKENS, CLAYTON-FAYETTE, COWETA, ELBERT, FRANKLIN, GRADY, JACKSON-BARROW, JASPER, LAMAR, MERIWETHER-HARRIS, MITCHELL, POLK, RABUN, RANDOLPH-TERRELL, SCREVEN, SOUTHWEST GEORGIA, SUMTER, TAYLOR, TIFT, TRI-COUNTY, WALTON, WILKES.

Ex-Officio members of the House of Delegates in attendance were:

Spencer A. Kirkland, Eustace A. Allen, C. H. Richardson, Sr., AMA Delegates; Hal M. Davison, President; W. Bruce Schaefer, President-Elect; H. Dawson Allen, Immediate Past President; David Henry Poer, Secretary-Treasurer; Lee Howard, Sr., First District Councilor; George R. Dillinger, Second District Councilor; W. G. Elliott, Third District Councilor; J. G. McDaniel, Fifth District Councilor; Henry H. Tift, Sixth District Councilor; Charles R. Andrews, Ninth District Councilor; Harry L. Cheves, Tenth District Councilor; C. F. Holton, Past President; Wm. R. Dancy, Past President; Wm. P. Harbin, Jr., Past President; Ralph H. Chaney, Past President; W. F. Reavis, Past President; Grady N. Coker, Past President; Chris J. McLoughlin, Public Service Committee Chairman; Ted F. Leigh, Scientific Exhibits Chairman; and Mr. Milton D. Krueger, Executive Secretary.

Report of Reference Committee No. 1

David R. Thomas, Jr., M.D., Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 1 met at 8:00 a.m., April 29, 1957, Room 700, Hotel DeSoto. Present were: David R. Thomas, Jr., Augusta, Chairman; John B. O'Neal, Elberton, Vice-Chairman; John P. Tucker, Moultrie; Floyd R. Sanders, Decatur; Edwin R. Watson, Macon; F. O. Garrison, Demorest; William B. Quillian, Cartersville; Ralph N. Johnson, Rome; Virgil B. Williams, Griffin, Secretary.

President

HAL M. DAVISON, M.D., Atlanta

During the past year officers and representatives from the headquarters office of the Medical Association of Georgia, have attended every district meeting. The caliber of the scientific programs has been excellent and the quality of entertainment unexcelled. The fellowship evidenced between doctors themselves and between their families promises well for the solidarity of our profession.

District Societies: The societies of nine districts have been active. The First District, which had no meeting last year, has become active again and plans to have

a meeting this spring. All are taking an active interest in what is happening in their state society and in national medicine. Adequate reports of the MAG activities and some of the activities of the AMA are given in the *Association Journal*, and in addition, the Councilor for the district, your president, and either Mr. Krueger or Mr. Kiser have given reports on interim activities. In some instances Dr. Poer, Dr. Schaefer, or one of your vice-presidents has also been present to help in this reporting. I believe that this report by the councilor for the district, followed by the report from representatives of the headquarters office, has done much to keep up the interest in the state association and that these reports should be made an integral part of every district meeting.

Vice-Presidents: The position of vice-president should be given more prominence, and the vice-president more activity. The vice-presidents should be invited and urged to attend the district meetings, along with the other officers.

For the last few years it has become conventional to elect two vice-presidents from the same town. Your president recommends that this procedure be discontinued and that one vice-president be selected from one part of the state and one from another part, so that they may be able to get to meetings more easily. By this means we would also get more representation on the Council from different areas of the state.

Medical Problems: Your president has made a study of medical problems over the United States, mainly problems concerning the corporate practice of medicine; the private practice of medicine by paid faculty members of medical schools; problems arising in hospitals; those concerning clinics owned and operated by doctors; and clinics and hospitals owned and operated by individuals or organizations; problems concerning the practice of medicine by anesthesiologists, by roentgenologists, and by pathologists in hospitals; problems concerning insurance; and he has made a report to Council based on the results of this study. A resume of part of this report has been given in the "President's Letters" throughout the year. Information contained in this report has been used by your Executive Committee and by the Council in setting some of the problems brought to them for their disposition.

You will have recommendations from the Council at this session concerning the corporate practice of medicine and the private practice of medicine by paid members of the medical faculties.

Hospitals: Problems between the medical staffs of hospitals on the one hand and the governing body and the lay administrator on the other are multiplying and becoming more serious. In most instances these problems arise from the fact that the administrator forms the liaison between the governing body and the medical staff. In other cases one doctor or a small group of doctors from a hospital staff have allied themselves with the administrator, with the governing body, or with both, and against their fellow doctors for selfish reasons. Most misunderstandings and most troubles of this kind can be prevented.

It is recommended to the House of Delegates that the Medical Association of Georgia strongly request that the medical staff of every hospital in the State of

Georgia, except government institutions, appoint a liaison committee from their staff to meet at regular intervals with the governing body of the hospital. No lay administrator can adequately speak for the medical staff and interpret its needs to the governing body, or the desires of the governing body to the medical staff.

Committees: As a whole the activity of your Association committees has been good, and some have accomplished all that they are supposed to do. We are grateful to them for their interest and for their work. However, a few committees have been inactive or lackadaisical in their attitude. If a committee is not needed it should be discontinued. At the beginning of every year the chairman and members of every committee should be notified of their appointment and should have adequate information about what their committee is supposed to accomplish.

It is recommended that at the proper time, which should be three to four months after the beginning of each year, the Council should call a meeting of the committee chairmen, either as a special meeting or to meet with Council at one of their regular meetings, to report on what they have done and what they are proposing to do. Chairmen or committee members who refuse to accept their responsibilities should be replaced by people who will. We have many active, capable, and interested members who will be glad to serve on committees. We need no paper committees.

It is further recommended that a special committee be appointed by Council to study our committee organization and make recommendations within the year for any changes they deem necessary.

Services and Finances: This year your Association is operating on a deficit budget. Above and beyond the deficit budget, by order of the House of Delegates, will be the bill for legal services of the lawyers retained to study the corporate practice of medicine. The fee for these lawyers was not included in the budget.

It is true that the speed of activities and the enlargement of services requested of the Headquarters Office over the last few years have been enormous, and it seems likely that these will continue to increase. The president at this time makes no recommendations. He is simply calling the attention of the House of Delegates to what is happening, but we may predict that either we must restrict the services provided by the Headquarters Office to stay within possibilities of the present income, or we shall have to increase our dues.

Council: I cannot conclude this report without expressing my admiration and appreciation for the work which your Council has done throughout the year. Both at regular meetings and at called meetings, practically 100 per cent of the members have been present. Some members of Council have been serving a long time, but it makes no difference whether the members are old or new, they all serve the state Association earnestly and with a great sense of responsibility.

During the past year, the Council has been meeting in different parts of the state and has been inviting the members of the local county societies to come to their meetings. Some have attended and have expressed the feeling that they understand a great deal more about the workings of the Association after doing so. I believe that this practice is a good one to perpetuate.

I desire also to express my appreciation to our Chairman of Council, Dr. J. W. Chambers, who has not only attended every meeting of the Executive Committee and of the Council, but also has made several trips out of the state in behalf of the Association. As a presiding officer, he is unusual and has had to guide the Council through some very difficult meetings. He is always calm and patient and is always tolerant of the opinions of others, but when it comes to actual principle, he is uncompromising. The society has been especially fortunate in having Dr. Chambers guide us through this past year.

We also owe special thanks to Dr. George R. Dillinger, vice-chairman of Council and vice-chairman of the Executive Committee, who has also been present at every meeting and in addition, has been chairman of the Finance Committee.

In closing, I would like also to express my thanks to Dr. Henry Poer, your secretary-treasurer, and your two executive secretaries, Mr. Milton Krueger and Mr. John Kiser. All three of them really live MAG. Their assiduous attention to the details of the business of our Association and their unfailing cooperation with everyone all over the State has been remarkable.

Reference Committee Recommendation—This committee strongly commends the President and offers him a vote of thanks for a difficult job well done. The committee recommends that the House of Delegates of the Medical Association of Georgia ask the medical staff of every hospital in the State of Georgia, except government institutions, to appoint a liaison committee from their staffs to meet regularly with the governing body of the hospital, and that each governing body of every hospital, except governmental institutions be advised of this action. The committee recommends that one vice-president be selected from one part of the state and one from another part. It is recommended that, at the proper time, which should be three to four months after the beginning of each year, the Council should call a meeting of the committee chairmen, either as a special meeting or to meet with Council at one of their regular meetings, to report in writing on what they have done and what they are proposing to do. Chairmen or committee members who refuse to accept their responsibilities should be replaced by members who will. We have many active, capable, and interested members who will be glad to serve on committees. It is further recommended that a special committee be appointed by Council to study our committee organization and to make recommendations within the year of any changes they deem necessary. This committee report is approved with emphasis on the above recommendations.

House of Delegates Action—Adopted the President's report as recommended by the reference committee on motion duly made and seconded.

Professional Conduct Committee

A. M. PHILLIPS, M.D., Macon, *Chairman*

There has been no called meeting of the Professional Conduct Committee during this past year. Only one case has been brought to the attention of this committee; this case was reviewed and studied by each member of your committee individually and a written opinion was rendered. This was forwarded to the secretary of the Medical Association of Georgia. In this report it was recommended that your committee meet during the session of the Medical Association of Georgia at Savannah and make recommendations to members of the Council. No other case was brought to the attention of this committee and this fact speaks well for the profession.

Reference Committee Recommendation—The Professional Conduct Committee is to be commended for its splendid report which is indicated by satisfactory relationships between physicians and the public. This report points up the need of continued effort to improve public relations. A. M. Phillips appeared before the

committee and discussed the two cases which were considered. It is recommended that this report be approved.

House of Delegates Action—Adopted the Professional Conduct Committee report as recommended by the reference committee on motion duly made and seconded.

ADDENDUM NO. 3—PROFESSIONAL CONDUCT COMMITTEE

A. M. PHILLIPS, M.D.

At the request of the Council, a called meeting of the Professional Conduct Committee was held in Macon on Sunday, April 7th. All members were present. The meeting was requested because it pertained to a matter that should be considered immediately. A letter of complaint had been received by the office of the Secretary of the Medical Association of Georgia from Mrs. L. F. Poole, Jr. of South Carolina. This letter was lengthy and somewhat bitter towards certain physicians at Warner Robins, Georgia. She attributed the death of her small child to neglect and indifference on the part of several physicians. This complaint was discussed and the action previously taken by Peach Belt Medical Society regarding this matter was read and discussed at length. The involved physicians were then interviewed singly, and their reports were discussed. After taking into consideration all the information available, it was unanimously decided that a letter from this committee should be drafted and sent to Mrs. Poole, expressing our sincere sympathy in her sorrow, at the same time we felt that the situation had been more of a series of unfortunate incidents rather than one of neglect.

This letter was drafted and forwarded to Council for action.

Two other cases were discussed, but since more information was needed in one case and the other case being one in which the matter had been referred to a local medical society which had already acted on the matter, no action was taken. These two last cases may be considered further during the Annual Meeting of the Medical Association of Georgia.

Reference Committee Recommendation—It is recommended that, Addendum No. 3, to the Professional Conduct Committee report, be approved.

House of Delegates Action—Adopted the Addendum No. 3, to the Professional Conduct Committee report, as recommended by the reference committee on motion duly made and seconded.

President-Elect

W. B. SCHAEFER, M.D., Toccoa

Your president-elect wishes to report that 1955 and 1956 have been, in his opinion, one of the busiest as well as the most profitable years in the history of the Medical Association of Georgia. As you all know, during this time the new Constitution and By-Laws have gone into effect, which increase the efficiency of your organization as well as your officers. The Executive Committee of Council is now meeting once a month; the Council is now meeting once every three months where previously it met only twice a year. During these meetings all activities of the Council and business of the organization is discussed and is usually acted upon. Your president-elect has attended most of these meetings as well as several district meetings with the president and with the executive secretary and other officers of the organization. The president-elect represented the organization at the meeting of the Fifth District. These meetings have all been good, the

fellowship fine, and scientific programs have been way above that I consider the national average. It is unfortunate that we do not have more of these local papers presented at a state level.

During this period Medicare has been established by the members. Only time will tell whether this is good. It has required a great deal of work by your officers in instituting this program. Your chairman of Council, your chairman of budget and your president, along with a special committee, have worked untiringly in this program. The new malpractice privilege of the constitution has been changed for the good of the organization as a whole, but I am sure to the detriment of some individual members. The Talmadge Hospital question is still pending but is coming more to a focal point, and I hope will soon be satisfactorily worked out.

It has been a pleasure to serve you as your president-elect. I have been very fortunate in being able to follow in the footsteps of your capable president and to have the advice and fellowship of the other officers, the executive secretary, Mr. Krueger, and his assistant, Mr. Kiser.

Reference Committee Recommendation—This reference committee commends the President-Elect on the enormous amount of work which he has performed in preparation for the year's task ahead. It is felt that his experience in service on the Council and the work of the past year indicates that he will serve well. All members of the Medical Association of Georgia wish him well and are willing and ready to assist him in the work of the Association. It is moved that his report be approved.

House of Delegates Action—Adopted the President-Elect's report as recommended by the reference committee on motion duly made and seconded.

Immediate Past President

H. DAWSON ALLEN, M.D., Milledgeville

As immediate past president, I have not been entirely without demands upon my time from the Council and the Committee on Grievances, along with two advisory board committees that have been held by virtue of my office as president and immediate past president.

I have attended the two meetings of the Advisory Committee to the Hospital Services Department of the State Board of Health and three committee meetings of the State Medical Education Board. I have also attended all Council and Executive Committee of Council meetings with the exception of two. In the capacity of immediate past president, I find myself able to take a much more relaxed and objective view of the proceedings of these committees and can see progress in the solution of all the problems facing the Medical Association of Georgia.

Reference Committee Recommendation—This committee received well the report of the Immediate Past President, and the report was reviewed in detail. The committee recommends that the House of Delegates commend and thank Dr. Allen for his untiring work during the past three years.

House of Delegates Action—Adopted the Immediate Past President's report as recommended by the reference committee on motion duly made and seconded.

Fourth District Councilor

J. W. CHAMBERS, M.D., LaGrange

Counties and Secretaries	Members December 31, 1956		Members December 31, 1955	
	MAG	AMA	MAG	AMA
Clayton-Fayette				
F. A. Sams, Fayetteville .	4	4	5	4
Coweta				
Geo. H. Mixon, Palmetto	18	5	19	5

Counties and Secretaries	Members December 31, 1956		Members December 31, 1955	
	MAG	AMA	MAG	AMA
Lamar				
S. B. Traylor, Barnesville	4	4	5	4
Meriwether-Harris				
J. W. Smith, Manchester .	13	6	17	3
Newton				
C. B. Palmer, Covington	14	12	12	11
Spalding				
James Skinner, Griffin . .	35	29	34	29
Troup				
J. R. Turner, LaGrange .	36	29	37	32
Upton				
H. D. Tyler, Thomaston .	16	13	17	13
	140	102	146	101

Reference Committee Recommendation—This committee commends the Fourth District Councilor for the splendid way in which he has discharged his duties representing the Fourth District and as Chairman of Council. It is moved that this report be approved.

House of Delegates Action—Adopted the Fourth District Councilor's report as recommended by the reference committee on motion duly made and seconded.

Fifth District Councilor

J. G. McDANIEL, M.D., Atlanta

I wish to report that as Councilor from the Fifth District, I have attended all regular Council meetings and all called meetings of Council since taking office in May 1956. The Fifth District Medical Society meeting was held November 1, 1956, at the Academy of Medicine, Atlanta, with an excellent attendance of Fifth District doctors.

Council duties to which I have been assigned include: Chairman of the Council Annual Session Committee; Chairman of the Council Special Committee on Ethics; and Temporary Chairman of the Council Finance Committee. The condition of the profession in the component societies of the Fifth District is good, and there have been no professional problems in the district that were not handled by the societies comprising the district.

Counties and Secretaries	Members December 31, 1956		Members December 31, 1955	
	MAG	AMA	MAG	AMA
DeKalb County				
H. G. Carter, Decatur .	59	58	51	50
Fulton				
T. J. Anderson, Atlanta .	836	680	830	646
	895	738	881	696

Reference Committee Recommendation—The Fifth District Councilor is to be congratulated on his active interest as a district councilor. The report indicates that he is doing an outstanding job as representative of the Fifth District on the Council. It is moved that this report be approved.

House of Delegates Action—Adopted the report of the Fifth District Councilor as recommended by the reference committee on motion duly made and seconded.

Mental Health Committee

RIVES CHALMERS, M.D., Atlanta, *Chairman*

This report is for the period of March 10, 1956, to March 10, 1957.

This committee held two meetings of the full committee. In addition, there was one subcommittee meeting, and another subcommittee performed extensive work in preparing a booklet for publication.

The first meeting was held in the Department of Neurology and Psychiatry at Eugene Talmadge Me-

morial Hospital with John Caldwell, Chairman of Department of Psychiatry, Medical College of Georgia, as host to the committee. Dr. Caldwell discussed plans for the development of an active teaching program in psychiatry and conducted a tour of the wards and clinic. The committee was impressed by the breadth and scope of Dr. Caldwell's planning, and it was our impression that this teaching program can make a real contribution to mental health in this state.

At this first meeting, Thomas G. Peacock, Superintendent of Milledgeville State Hospital, presented the annual report of the hospital and discussed the program and problems at the hospital with the committee. Members of the committee were primarily concerned with ways and means of bringing about better understanding of the hospital and its activities by the medical profession and the general public in Georgia. It was decided to appoint a subcommittee to discuss this further with Dr. Peacock at a later date. The committee was also interested in promoting the use of psychiatric beds in Hill-Burton Hospitals throughout the state so that more patients can be treated in local hospitals rather than being housed in jail before being transferred to the State Hospital. It is recognized that some form of post graduate training for physicians in local communities will probably be necessary in order to encourage their treating more psychiatric patients in local hospitals. Dr. Rice, of the State Health Department, presented a plan for the establishment of psychiatric screening centers in designated hospitals in the state where psychiatric evaluation and early intensive treatment would be provided for selected cases with provision for the state to subsidize the cost of this treatment as part of the state plan for hospitalization of the mentally ill. Mrs. Charles Smith of Columbus, Chairman of the Mental Health Committee of the Woman's Auxiliary to the Medical Association of Georgia, reported on activities of her committee and discussed plans for encouraging local auxiliaries to promote the use of a series of letters on mental health to seniors in the high schools in Georgia. These letters are entitled "Milestones In Marriage," and the committee went on record as approving this series.

The second meeting of the full committee was held February 17, 1957, at the Biltmore Hotel in Atlanta. At this meeting the chairman reported on his attendance at the Third Annual Conference of Mental Health Representatives of State Medical Associations sponsored by the Council on Mental Health to the American Medical Association in Chicago on November 16-17, 1956. This conference was primarily concerned with discussion groups considering the following four topics: (1) use of hypnosis in medical practice, (2) alcoholic patient as a mental and hospital management problem, (3) benefits and problems encountered by general practitioners with the use of new tranquilizer drugs for patients with emotional illness, and (4) in-patient psychiatric care for children. Reports on these four topics are available and have been circulated to members of this committee. Richard Felder reported on plans for the final preparation of the booklet on Hospitalization of the Mentally Ill prepared by Arthur M. Knight, Jr., and the subcommittee on continuing information. This booklet is to be ready for distribution at the time of the state meeting in April. Thomas J. Van Sant reported on activities of the subcommittee assigned to meet with Dr. Peacock and recommended plans to im-

prove understanding of activities at the State Hospital by the members of the medical profession and the general public in Georgia. This committee made recommendations related to two specific plans, (1) a plan for closer communication between the family physician and the physicians at the State Hospital regarding treatment for individual patients; follow-up after their return from the State Hospital was discussed in detail and is contained in the report of that subcommittee. (2) It is proposed that a movie be produced predicting the process of care for a mentally ill person from the onset of his illness through commitment and hospitalization to the after-care necessary upon his return to his home community. The committee is following up on this suggestion in the hope that such a movie may be produced during the next year. In addition, the subcommittee discussed the possibility of members of the medical profession throughout the State of Georgia accepting responsibilities for some voluntary participation in the program of care for patients at the State Hospital for the purpose of providing closer coordination between the medical profession and the staff of the State Hospital and also providing a type of special service to patients in the State Hospital which is not presently available to them by the regular staff at the hospital. This plan will be discussed further and definite recommendations made to the Medical Association at a later date.

In addition to the above activities, members of this committee have participated with local and state organizations in mental health programs and given assistance to the Georgia Association for Mental Health in the promotion of its plans for a legislative and a fund raising program in the state.

The committee is especially pleased to see a section on nervous and mental diseases in the program of the annual meeting of the Association. The Study Commission on Mental Health recommended by this committee last year has been recommended by the State Legislature. It is the hope of this committee that this commission will make an active study of the mental health resources and needs in Georgia and come up with a sound legislative program designed to promote mental health for each individual in the state.

This committee has no specific recommendations to make to the House of Delegates this year, but does plan to follow up on those activities already under way.

Reference Committee Recommendation—The report of the Mental Health Committee was discussed at length. The members of this committee are to be commended for their untiring efforts toward bettering the welfare of the mentally ill of this state. Dr. Chalmers, Chairman of the Mental Health Committee, and J. R. Shannon Mays appeared before the committee and discussed that part of the report concerning the hospitalization of the mentally ill. It is recommended that this report be approved in its entirety.

House of Delegates Action—Adopted the report of the Mental Health Committee as recommended by the reference committee on motion duly made and seconded.

Resolution No. 2

Hospitalization of the Mentally Ill

RIVES CHALMERS, M.D., Atlanta

WHEREAS, the laws of our state governing care of the mentally ill are based on principles which are antiquated, inadequate, and often inequitable; and,

WHEREAS, there is a growing recognition of the need for increased psychiatric facilities; and,

WHEREAS, some communities are moving to meet this need;

THEREFORE BE IT RESOLVED that the Medical Association of Georgia be put on record as favoring passage of the Involuntary Hospitalization Section of the Draft Act Governing Hospitalization of the Mentally Ill as published by the Department of Health, Education and Welfare.

(Resolution No. 2 and the following Resolution No. 9 were so similar in content that they were acted on jointly as noted after Resolution No. 9.)

Resolution No. 9

Hospitalization of the Mentally Ill

BIBB COUNTY MEDICAL SOCIETY

WHEREAS, the laws of our state governing care of the mentally ill are based on principles which are antiquated, inadequate, and often inequitable, and

WHEREAS, there is growing recognition of the need for increased psychiatric facilities, and

WHEREAS, some communities are moving to meet this need;

THEREFORE BE IT RESOLVED that the Medical Association of Georgia be put on record as favoring passage of the Involuntary Hospitalization Section of the Draft Act Governing Hospitalization of the Mentally Ill as published by the Federal Security Agency.

Reference Committee Recommendation—Reference Committee No. 1 endorses Resolutions No. 2 and No. 9 on medical procedures for hospitalization of the mentally ill. This committee hereby requests that the House of Delegates of the MAG go on record as favoring passage of this legislation. The Committee on Legislation is requested to make every effort to promote enactment of this legislation by the Georgia General Assembly. It is recommended that the Governor of Georgia and the Sanitarium Committee of the General Assembly be furnished with a copy of this action.

House of Delegates Action—Adopted Resolutions No. 2 and No. 9 as recommended by the reference committee on motions duly made and seconded.

History and Vital Statistics Committee

J. CALVIN WEAVER, M.D., Atlanta, Chairman

The report of the History Committee necessarily has to be short. The entire report revolves around the writing of the medical history of Georgia, which I have been working on for many years.

Only recently a committee of three members of the Association, C. C. Aven, C. W. Strickler, Jr., and Herbert Alden, joined me in a discussion at my home, and we went over the entire subject of the history. The cost of publication and the progress we have made were put into a report, which will be presented to the House of Delegates.

Since it seems that some action might be taken this year toward getting the history published, I have agreed to do everything in my power to put the finishing touches to it and have it completed within the year. The work on Georgia as a colony and on Georgia as a province have had a final writing; the material from the Revolutionary War on up through the Reconstruction Days in Georgia is at hand and is being done. I am going about this at every spare moment and will work on it until it is finished. It has been a long, tough job, and I am glad the end is in sight.

The report of the above named committee will give you all the details and will make it unnecessary for me to enumerate them in this report.

Reference Committee Recommendation—Reference Committee No. 1 expresses thanks to J. Calvin Weaver for his continued interest and work in history and vital statistics and suggests that a letter of commendation be sent Dr. Weaver. The report was approved.

House of Delegates Action—Adopted the report of the History and Vital Statistics Committee as recommended by the reference committee on motion duly made and seconded.

Sixth District Councilor

HENRY H. TIFT, M.D., Macon

The spring meeting of the Sixth District Medical Society was held in the Dublin Veterans Administration Hospital on April 11, 1956. A special guest present was Hal M. Davison, President-Elect of the Medical Association of Georgia. An excellent scientific program was presented, with papers by Dr. William Shirley, Dr. John Lawrence, Dr. L. E. Dickey, Jr., Dr. R. W. McAllister and Dr. Thomas L. Ross, Jr. Following the scientific meeting, a delightful social hour was held at the Dublin Country Club.

The winter meeting of the society was held at the State Health Department Building in Macon on December 5, 1956. There were over 50 members and guests present, including Dr. Bruce Schaefer, President-Elect of the Medical Association of Georgia. Papers were presented by Dr. Tom Williams, Dr. Claude Pennington, Dr. Ralph Newton and Dr. William Somers. A highlight of the program was a clinico-pathological conference conducted by Dr. Thomas Findley of Augusta. Following the scientific session, a social hour was held at the Idle Hour Country Club.

The following table indicates the number of members present in the various county societies comprising the Sixth District:

Counties and Secretaries	Members December 31, 1956		Members December 31, 1955	
	MAG	AMA	MAG	AMA
Baldwin				
H. E. Campbell, Milledgeville	26	13	28	12
Bibb				
E. C. McMillan, Macon .	149	138	155	140
Jasper				
E. M. Lancaster, Shady Dale	3	3	4	3
Jefferson				
Walter Revell, Louisville .	8	4	7	4
Laurens				
John A. Bell, Dublin . .	29	12	36	10
Washington				
F. T. McElreath, Tennille	12	11	13	10
	227	181	243	179

Reference Committee Recommendation—The Sixth District Councilor is to be commended for his excellent work. The report was approved.

House of Delegates Action—Adopted the report of the Sixth District Councilor as recommended by the reference committee on motion duly made and seconded.

Sixth District Vice-Councilor

GEORGE H. ALEXANDER, M.D., Forsyth

My activities as Vice-Councilor were somewhat restricted during the first six months because of illness.

During the month of February, as requested by the Legislative Committee, I sent telegrams to members in each county of the district asking that they contact their legislators to enlist aid in defeating the osteopathic bill. I attended the special Council meeting in Macon

on January 27, 1957, as Vice-Councilor and the March 9-10, meeting in Albany, serving as Councilor in Dr. Tift's absence.

Reference Committee Recommendation—The Sixth District Vice-Councilor is to be commended for his excellent work. The report was approved.

House of Delegates Action—Adopted the report of the Sixth District Vice-Councilor as recommended by the reference committee on motion duly made and seconded.

Industrial Health Committee

DUNCAN SHEPARD, M.D., Atlanta, *Chairman*

The Industrial Health Committee of the Medical Association of Georgia met on November 18, 1956, in Atlanta. At that time we discussed the request of the Industrial Health Council of Greater Atlanta, Inc., for approval of our committee to operate throughout the state. It was the feeling of the committee that this organization should apply to the various county medical societies so that any issues involved between them could be settled at a local level. In addition, we discussed other activities of the committee, such as the proposed change in the Workmen's Compensation Laws.

The committee was represented at the 17th Annual Congress on Industrial Health at Los Angeles, California, by Allen M. Collinsworth.

The principal work of the committee for the past year was an effort, in cooperation with the Committee on Legislation, to effect an amendment to the Workmen's Compensation Laws of Georgia; briefly, this change was desirable in that it would allow the employment of those who are physically handicapped from heart disease and/or cerebro-vascular accidents. Our effort was to have the law amended so that these diseases, if occurring on the workman's usual job, would not be compensable. It was thought that if this could be accomplished, the majority of people who are now unemployable due to an old cerebro-vascular accident, myocardial infarction or cardiac failure, would become employable. Unfortunately, the amendment was defeated in the state legislature.

Reference Committee Recommendation—Reference Committee No. 1 commends the Industrial Health Committee for the fine work done during the past year. Appreciation is expressed for their continued interest. It is felt that they should continue their efforts in the future to have workmen's compensation laws changed to include the provisions for employment of the physically handicapped.

House of Delegates Action—Adopted the report of the Industrial Health Committee as recommended by the reference committee on motion duly made and seconded.

State Advisory Committee to the Selective Service System

DAVID HENRY POER, M.D., Atlanta, *Chairman*

The following report is submitted to show the activities and work of the Georgia State Advisory Committee to the Selective Service System under my chairmanship during the past year.

During the latter part of 1955, the committee was advised that the needs of the military services for medical officers for the period of July 1, 1956, through June 30, 1957, would be such as to require active duty of all interns and residents who have not already satisfied their military liability and perhaps some liable physicians of Priority III who are older and perhaps established in practice. During the past year, calls

have been levied by Selective Service for five physicians to be delivered in February 1956; 12 to be delivered in July 1956; four to be delivered in October 1956. Another call was issued in December 1956 for the delivery of 14 physicians in February 1957.

These calls have included orders for induction sent to six Priority I physicians: George T. Olmstead, Jr., Savannah; William H. Bryan, Jefferson City, Mo.; Lewis L. Hatcher, Alma; Joshua S. Williams, Macon; John J. Allen, Trion; and Jerome B. Bryant, Jr., Rome. One priority II physician was called: Edgar Harris Pierce, Rochester, Minnesota. The following Priority II physicians, Special Registrants of Georgia, were issued calls during the year:

Robert L. Pence, Jr., Chattanooga, Tennessee; Floyd R. Cooper, Jr., Canton; Donald C. Chait, Atlanta; Waldo E. Floyd, Atlanta; Albert R. Howard, Athens; John G. Madry, Jr., Atlanta; Edwin C. Pound, Jr., Atlanta; Frank T. Robbins, Brentwood, Missouri; Frank C. Wilson, Jr., Atlanta; Roy A. Wiggins, Jr., New York, New York; Paul A. Lavietes, Cleveland, Ohio; Jasper F. Thompson, Washington, D. C.; Henry T. Clay, Macon; George D. Gowder, Jr., Atlanta; John E. Harrison, Millen; Esley Earle Lewis, North Augusta, South Carolina; William H. Lucas, Jr., Cedartown; Milton G. Middleton, Jacksonville, Florida; Keith A. Quarterman, Charleston, South Carolina; Calvin L. Thrash, Jr., Atlanta.

The number of Priority I men in the state has been materially reduced. At present, there are fourteen Priority I physicians with Class 2-A deferments. Eight of these men are considered essential in their present positions by the committee. The other six are men who have been declared available by the committee but have been continued in a deferred classification by the local boards. The local board of one county has continued to grant deferment to three Priority I physicians even though the committee has repeatedly recommended that they be made available. During the year, the State Director has appealed the 2-A classification of three Priority I men. Two of these physicians were classified 1-A by the Appeal Board. The third was classified 2-A by the Appeal Board.

At present there are eight Priority I Georgia physicians who are classified 1-D (members of reserve components), but who have not yet been called to active duty.

As we are advised of the pending release from active duty in the armed forces of physicians from Georgia, we write them letters of welcome and offer any assistance possible in regard to further training or relocating.

During 1956 the committee has considered the essentiality of some seventy-five special registrant physicians and submitted recommendations. The dental and veterinary sub-committees have also been active in considering the cases of all special registrants submitted to them.

There have been no changes in regulations or policy concerning special registrants during the past year. In accordance with policy, we continue to not recommend deferment for residency training beyond the first year of internship, unless the physician is included in the Department of Defense's Residency Consideration Program, or perhaps some very exceptional case.

Six years of service has been completed by the committee whose personnel has remained the same during this time. All members have exhibited a keen

sense of responsibility for the work of the committee. We are very grateful to the district committees for the excellent cooperation which they have given us and without which we would have been unable to function satisfactorily in our advisory capacity. Our committee will continue to serve in the best interests while our services are needed.

In line with our policy of rotating the chairmanship each year, L. Minor Blackford has been chosen to head the committee during 1957 with T. F. Sellers as his co-chairman. These appointments meet with the approval of the National Advisory Committee.

This committee has been carrying on its thankless duties for over five years, and frankly looks forward with a great deal of pleasure to that magic date, June 30, 1957, when its work will be considerably curtailed or perhaps abolished entirely. On that date, the law setting up the special doctors' draft will come to an end thus ending the unfair double jeopardy to which the members of the medical profession have been subjected since the beginning of the Korean conflict. During the years of its existence this committee has reviewed the essentiality of approximately 929 physicians who were subject to the draft call, and of these, 111 have entered the military medical service. We are happy to report that all of these men have returned from their military duties without a single mortality or a serious accident.

The decisions of this Advisory Committee were accepted by the State Director in all but a very few cases and all these have finally been brought before the State Appeal Board for review. The present State Director, Colonel Mike J. Hendrix, has been thoroughly cooperative with the Board and appreciative of the difficulties under which we have operated. Unfortunately, this was not true before he took over this assignment.

In the closing days of the activities of this committee, we recommend that special commendation be given to:

(1) All of the doctors in Georgia who have cooperated so well with this program and specifically to the physicians who in many instances gave up their practice at great sacrifice and accepted their military obligations without protest.

(2) To the many county and district advisory committees who gave liberally of their time to study the cases of all the physicians living in their areas when requested by the central committee, and

(3) To the State Director, Colonel Mike J. Hendrix, and the members of his staff, and particularly to Mrs. Gladys Warren, who have given unsparingly of their time in trying to make the work of this committee a success.

It has been a pleasure to serve as Chairman of the Georgia State Advisory Committee during 1956. I express to all members of the committee and to the district committees my sincere appreciation for their cooperation.

Reference Committee Recommendation—David Henry Poer, Chairman of the Committee on Selective Service, kindly appeared and discussed the report. It appears that the services of this committee might well be needed in the future, and the committee should be kept intact until their services are no longer needed.

House of Delegates Action—Adopted the report of the Selective Service Committee as recommended by the reference committee on motion duly made and seconded.

ADDENDUM NO. 6—STATE ADVISORY COMMITTEE TO SELECTIVE SERVICE

DAVID HENRY POER, M.D.

In conformity with the recommendations of the Council on National Defense of the AMA, it is recommended that the House of Delegates approve the following:

(1) Oppose extension of the Doctor Draft Act unless need is definitely demonstrated.

(2) Oppose military scholarships for medical students.

(3) Approve elevation of the surgeon-general of the Army to the rank of lieutenant-general.

(4) Oppose to build and operate a separate medical college by the government (Medical Military Academy).

(5) Oppose increase of physician-troop ratio as requested by military authorities (from 3:1000 to 3.4:1000).

(6) Instruct AMA Delegates to present these decisions to the House of Delegates of the AMA with recommendations that similar action be taken.

Reference Committee Recommendation—The addendum to the Selective Service Report was presented and is approved except for item No. 2. ("Oppose military scholarships for medical students") which was discussed and received as information without action. This committee feels that every effort should be made by the Armed Forces to coordinate their services and to eliminate duplications of medical services wherever possible. It is recommended that the committee addendum be approved as changed.

House of Delegates Action—Adopted Addendum No. 6, to State Advisory Committee on Selection Service, as recommended and altered by the reference committee on motion duly made and seconded.

Fifth District Vice-Councilor

CHARLES S. JONES, M.D., Atlanta

Under the guidance of J. G. McDaniel, this Vice-Councilor has had a very pleasant and enlightening experience during the past year as a representative from your Fifth District. Three matters stand out in interest from my standpoint:

(1) The malpractice insurance program which has been developed in Georgia through the cooperation of the Saint Paul-Mercury Indemnity Company is now functioning well. The machinery which was set up to handle potential malpractice suits is working well and the reduced premium rate, thus far, seems to well justify the efforts which were made to get this program started.

(2) As all of the doctors of Georgia know, the Medicare Program under which dependents of members of the uniformed services are given medical and surgical care at government expense is now in full swing in Georgia. Unlike many states this program from a standpoint of professional fees is being handled by your medical association. The fee schedule was negotiated with the Department of the Army in Washington, D. C. I was present at these negotiations. It was a difficult and trying ordeal, but the fee schedule obtained, for the moment, seems fairly satisfactory. There are many fees for various procedures which have not yet been finally settled. The main consulting body for this program is a review board which meets when necessary and goes over the various problems. There are five doctors on this review board, and I am numbered among the board. We have had one meeting and anticipate another meeting in the near future.

(3) During the past year, as a representative of the Insurance Committee of the Medical Association of Georgia, I have spent some time investigating the possibility of getting additional life insurance on a group basis for the doctors of Georgia. In the course of this investigation members of the insurance industry have been freely consulted, and their advice requested on the various aspects of life insurance as it concerns members of the medical profession. From the results of this study, your Vice-Councilor reached the conclusion that additional group life insurance would not be advisable. During the course of the investigation, several men who might be considered some of the leading authorities on life insurance in this part of the country recommended that the soundest and cheapest life insurance for doctors, at the present time, would be the Social Security program. Following their advice it was recommended that the Council of the Medical Association of Georgia support the philosophy of compulsory Social Security for doctors. This matter has been referred by Council to the House of Delegates and will be further considered at the annual meeting of the Medical Association of Georgia.

Reference Committee Recommendation—The Vice-Councilor from the Fifth District is to be congratulated for the work and thought which has gone into his report. The report was accepted and approved with the exception of Section 3 dealing with the Social Security question. This matter was referred to Reference Committee No. 4 with whom Reference Committee No. 1 held a joint meeting. Reference Committee No. 4 is to report on the joint No. 4's action and the pursuant House of Delegates action on this action taken at this time. (See page 299 for Reference Committee matter of Social Security.)

House of Delegates Action—Adopted the Fifth District Vice-Councilor's report as recommended and altered by the reference committee on motion duly made and seconded.

It was moved and duly seconded that the report of Reference Committee No. 1 be accepted as a whole and it was so ordered.

Report of Reference Committee No. 2

T. A. Sappington, Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 2 met at 8 a.m., April 29, 1957, in Room 408, Hotel DeSoto, Savannah. Members present were T. A. Sappington, Thomas-ton, Chairman; Don F. Cathcart, Atlanta, Vice-Chairman; A. V. Gafford, Rome, Secretary; William H. Fulmer, Savannah; J. D. Applewhite, Macon; M. F. Arnold, Hawkinsville; R. H. Chaney, Augusta; Joseph B. Mercer, Brunswick; A. S. Fitzhugh, Griffin; H. B. Cason, Warrenton.

Speaker of House of Delegates

THOMAS W. GOODWIN, M.D., Augusta

The speaker of the House of Delegates has continued to take an increasing interest in the affairs of the Association due to the fact that he has recently become

a member of Council. It is felt that this has been an extremely wise move since it keeps the speaker closely in touch with affairs of the Association and enables him to know what is going on at all times, and it places him in the position of being better able to interpret for the members the different phases of any problem that might arise in the discussions of the House of Delegates. The speaker of the House has attended all meetings of Council as required by the Constitution and By-Laws and has appointed all the committees that are required of him. It has been and will continue to be the policy of the Speaker of the House of Delegates to see to it that the deliberations of the House are conducted in an orderly manner, with emphasis being placed on the idea that these discussions shall always be eminently fair to all parties and interests concerned.

Reference Committee Recommendation—The report of the Speaker of the House of Delegates was received for information, and the reference committee commended Dr. Goodwin for his work as the Speaker. I move the adoption of this section of the report.

House of Delegates Action—Adopted the report of the Speaker of the House as recommended by the reference committee on motion duly made and seconded.

Vice-Speaker of House of Delegates

FRED H. SIMONTON, M.D., Chickamauga

As Vice-Speaker of the House of Delegates of the Medical Association of Georgia, I have no activity to report this year.

Reference Committee Recommendation—The report of the Vice-Speaker of the House of Delegates was received for information. I move the adoption of this section of the report.

House of Delegates Action—Adopted the report of the Vice-Speaker of the House as recommended by the reference committee on motion duly made and seconded.

AMA Delegates

C. H. RICHARDSON, SR., M.D., Macon

EUSTACE A. ALLEN, M.D., Atlanta

SPENCER A. KIRKLAND, M.D., Atlanta

Since our last annual meeting, the American Medical Association has held two meetings: the annual meeting was held in Chicago, June 11-15, 1956; the clinical session was in Seattle, November 26-30, 1956. All three of your delegates attended all meetings of the House of Delegates at each session.

The 105th Annual Meeting of the American Medical Association convened in Chicago, June 11-15, 1956, with a total registration of 24,368, and of this number 9,969 were physicians.

David B. Allman of Atlantic City was elected president-elect of your AMA. Dr. Allman has been a member of the Board of Trustees since 1951 and Chairman of the Committee on Legislation. Besides his many other duties, he has been the physician for every Miss America Contest in Atlantic City since its inauguration.

Dr. Hugh H. Hussey, Professor of Medicine at Georgetown University, Washington, D. C., and Medical Editor of *GP*, the journal of the American Academy of General Practice, was elected to the Board of Trustees to fill Dr. Allman's place. Dr. Julian P. Price, Florence, S. C., was re-elected to the board. Dr. F. S. Crockett of Lafayette, Indiana, became vice-president, and Dr. Robertson Ward of San Francisco, was elected to the Judicial Council.

The House of Delegates selected Dr. Walter L. Bierring of Des Moines, Iowa, as recipient of the 1956 Distinguished Service Award of the American Medical Association, for his long and outstanding contributions to medicine and humanity. Dr. Bierring is a past-president of the AMA.

Hospital accreditation, evaluation of graduates of foreign medical schools, private practice by medical school faculty members, federal aid to medical education, and premature publicity on new drugs were a few of the major subjects brought before the House of Delegates.

The Committee to Review the Functions of the Joint Commission on Accreditation of Hospitals came to the following conclusions:

- "1. Accreditation of hospitals should be continued.
- "2. The Joint Commission should maintain its present organizational representation.
- "3. The Board of Trustees should report annually to the House of Delegates on the activities of the Joint Commission.
- "4. Physicians should be on the administrative bodies of hospitals.
- "5. General practice sections in hospitals should be encouraged.
- "6. Staff meetings required by the Joint Commission are acceptable, but attendance requirements should be set up locally and not by the commission.
- "7. The Joint Commission should not concern itself with the number of hospital staffs to which a physician may belong.
- "8. The Joint Commission is not and should not be punitive.
- "9. The Joint Commission should publicize the method of appeal to hospitals that fail to receive accreditation.
- "10. Reports on surveys should be sent to both administrator and chief of staff of hospitals.
- "11. Surveyors should be directly employed and supervised by the Joint Commission.
- "12. Surveyors should work with both administrator and staff.
- "13. New surveyors should receive better indoctrination.
- "14. Blue Cross and other associations should be requested not to suspend full benefits to non-accredited hospitals until those so requesting have been inspected.
- "15. The American Medical Association should conduct an educational campaign for doctors relative to the functions and operations of the Joint Commission.

"16. The committee also suggests that the American Medical Association and the American Hospital Association encourage educational meetings for hospital boards of trustees and administrators either on state or national levels to acquaint these bodies with the function of accreditation.

"17. This committee asks to be discharged upon submission of this report to the House of Delegates."

The House of Delegates approved these recommendations and *also* the reference committee suggestion that the following statement be added to strengthen the report:

"The committee recommends that the commissioners to the Joint Commission on Accreditation of Hospitals, appointed by the Board of Trustees of the American Medical Association, urge the commission to study:

"1. The problems of the exclusion from hospitals and arbitrary limitation of the hospital privileges of the general practitioner, and

"2. Methods whereby the following stated principles may be achieved:

"The privileges of each member of the medical staff shall be determined on the basis of professional qualifications and demonstrated ability.

"Personnel of each service or department shall be qualified by training and demonstrated competence, and shall be granted privileges commensurate with their individual abilities."

The House of Delegates approved in principle a program for the evaluation of graduates of foreign medical schools seeking hospital positions in the United States.

The proposed plan calls for establishment of a central administrative organization to evaluate the medical credentials of foreign-trained physicians desiring to serve as interns or residents in American hospitals. Basic requirements would include satisfactory evidence of at least 18 years of total formal education, including a minimum of 32 months in medicine exclusive of any time which in this country would be considered as premedical study or internship. Applicants with satisfactory credentials then would take a screening examination to determine their medical knowledge and their facility with the English language. Successful applicants then would be certified to hospitals and other interested organizations, with the approval of the foreign-trained physician concerned.

Another action by the House involved the problem of private practice by medical school faculty members, which has been under study by the Committee on Medical and Related Facilities of the Council on Medical Service. The House adopted a Council report which stated "that it shall be the policy of the American Medical Association that funds received from the private practice of medicine by salaried members of the clinical faculty of the medical school or hospital should not accrue to the general budget of the institution and that the initial disposition of fees for medical service from paying-patients should be under the direct control of the doctor or doctors rendering the service."

It was further recommended that adequate liaison be developed and maintained between each county medical society and any medical school or schools in its area; that the Council on Medical Education and Hospitals and the Association of American Medical Colleges urge all medical schools to assist and work with medical societies in developing such liaison; and that publicity emanating from a medical school be in good taste and of a type which has the approval of the general medical community in that area.

The adopted report also said: "It is not in the public or professional interest for a third party to derive a profit from payment received for medical services, nor is it in the public or professional interest for a third party to intervene in the physician-patient relationship."

The AMA House of Delegates reaffirmed its policy on federal aid to medical schools which approves such

legislation in principle with certain reservations concerning details of some provisions. We desire to improve medical education, but we are opposed to the socialization of medical education and medical practice in this country.

The House of Delegates deplored the premature releasing of new drugs and premature publicity, concerning these drugs, to the public. A resolution was adopted to appoint a liaison committee to meet with representatives of the pharmaceutical manufacturers to correct these conditions.

Your delegates from Georgia introduced a resolution on automobile safety which was adopted in principle, and the House recommended that the county medical societies, state associations, and the AMA take an active lead in this problem.

Many other actions were taken but space prevents a complete review of all activities.

The Tenth Clinical Meeting of the American Medical Association convened in Seattle, November 27-30, 1956. The total registration was 6,282, which included 2,813 physicians. Georgia had 12 registered, including your three delegates. In spite of fog, famine, and fatigue we arrived in time, having to travel the last 100 miles by bus.

There was talk in Seattle about continuing the clinical sessions. A resolution from your delegates was introduced at the Chicago meeting which was disapproved. A similar resolution was introduced at Seattle and was received with favor; perhaps due to the difficulty in reaching our meeting place. After much discussion, pro and con, the House of Delegates accepted a reference committee report which said, "We believe that the interim session should be continued because of the public relations value of these meetings to the Association and the educational value to physicians and the general public in the various geographical areas involved."

The House of Delegates acted on 26 resolutions with perhaps a third on medical ethics. Others were on veterans' medical care, radioactive isotopes, hospitalization for alcoholic patients, and a report of the Committee on Medical Practices. To sit through any session of the House, one is soon convinced with the fact that the medical profession is concerned with the socioeconomic aspects of medicine as well as the science of medicine. Dr. Dwight H. Murray's address was praised by physicians and the press. The reference committee which studied his address said, "It was one of the finest delivered by any president of the American Medical Association in recent years." Every physician should read and digest this talk.

The AMA General Practitioner of the Year Gold Medal Award went to Dr. Edward M. Gans of Harlowton, Montana. He is 80 years of age and has practiced medicine for 51 years.

The proposed *Principles of Medical Ethics* received the greatest attention at this session. You are familiar with the new *Guide to Ethical Conduct* introduced at the Annual Session in Chicago. It is divided into 10 sections. Out of the general discussion, the reference committee came to the opinion that at least four areas in sections six and seven need more specific attention.

SECTION 6. A physician should not dispose of his services under terms or conditions which will interfere with or impair the free and complete exercise of

his independent medical judgment and skill or cause deterioration of the quality of medical care.

SECTION 7. In the practice of medicine, a physician should limit the source of his professional income to medical services actually rendered by him to his patient.

The sections that need more attention are: (1) dispensing of drugs; (2) division of fees; (3) the corporate practice of medicine, and (4) greater emphasis concerning the relationship between physicians and patients. They also suggested that Section 10 read as follows:

"The responsibilities of the physician extend not only to the individual but also to society and deserve his interest and participation in activities which have as their objective the improvement of the health and welfare of the individual and the community."

So up to now, there has been no change in our *Principles of Medical Ethics*. If you have any suggestions to take to the New York meeting, please convey them to your delegates.

The Council on Medical Service recommends a revision of AMA policy on Veterans Care to read:

"With respect to the provision of medical care and hospitalization benefits for veterans in Veterans Administration and other federal hospitals, that new legislation be enacted limiting such care to veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated."

The Reference Committee on Insurance and Medical Service endorsed in principle this report.

The President of the American Bar Association, Mr. David F. Maxwell, addressed the House of Delegates. He stressed closer cooperation between the legal and medical professions. Better understanding of the two professional procedural and ethical problems in litigations and other areas, where the two professions come in contact, will help to serve the public better.

The World Medical Association needs the support of every physician. At its meeting in Havana in October 1956, a great unity developed. Five hundred physicians representing 53 member nations gathered to help establish professional standards on ethics of physicians, principles for guides for medical service, and social security. No nation behind the iron curtain is a member of this organization. A sense of unity and community spirit was much more apparent at this meeting than any previous session.

The Seattle meeting of the House of Delegates had one distinguishing feature. Dr. M. Louise Gloecker, from Pennsylvania, became our first woman delegate.

Reference Committee Recommendation—The AMA Delegates' report is accepted as information with the suggestion that the following be added to conclusion number four as given in the report under the heading, "The Committee to Review the Functions of the Joint Commission on Accreditation of Hospitals." So that the sentence shall read as follows: "Physicians should be on the administrative bodies of hospitals, and these physicians should be elected by the medical staff of the said hospital." We commend members and delegates to the AMA for their excellent work and feel sure they will continue their activities in the future. I move the adoption of this section of the report.

House of Delegates Action—Adopted the AMA Delegates' report as recommended and altered by the reference committee on motion duly made and seconded.

Tenth District Councilor

H. L. CHEVES, SR., M.D., Union Point

At this meeting, I pass the responsibilities as well as the pleasures which go with the office to my successor. I have had the honor of serving this district for nearly 20 years and have been a party to seeing the Council become of age. By this, I mean that the Council has now taken on the duties prescribed for it by the Constitution of the Medical Association of Georgia. Your Council is a body of hard working men who give unselfishly of their time to see that the affairs of the MAG are conducted properly. It would take many pages to enumerate the events as they have happened over the years, but it is enough to say that 20 years ago the Council was practically a non-functioning body and today it is truly a working body.

The Tenth District has increased in membership, both to the MAG and to the AMA as the chart will show.

In the past year, two meetings were held. Both were well attended and fine programs presented.

A new medical society has been formed of members from Hart and Franklin Counties. With the organization of this new society, it places the Tenth District in fine condition as to county societies.

I would like to take this opportunity to express my gratitude to my district for the honor they have bestowed on me in allowing me such a long term of office.

Counties and Secretaries	Members December 31, 1956		Members December 31, 1955	
	MAG	AMA	MAG	AMA
Crawford W. Long				
M. N. Dalton, Hartwell .	10	7	10	8
McDuffie				
B. S. DuBose, Athens . .	44	36	44	35
Elbert				
W. H. Pool, Elberton . .	16	9	17	9
Franklin-Hart				
Joe Garrison, Thomson .	6	5	7	6
Oconee Valley				
George Green, Sparta . .	14	10	14	8
Richmond				
Theodore Everett, Augusta	218	168	202	156
Walton				
H. B. Nunnally, Monroe .	11	10	11	10
Warren				
A. W. Davis, Warrenton .	2	2	2	2
Wilkes				
A. W. Simpson, Washington	12	8	13	8
	333	255	320	242

Reference Committee Recommendation—The report of the Tenth District Councilor is accepted for information. I move the adoption of this section of the report.

House of Delegates Action—Adopted the Tenth District Councilor's report as recommended by the reference committee on motion duly made and seconded.

Legislation Committee

M. F. SIMMONS, M.D., Decatur, *Chairman*

In accordance with the directives of the House of Delegates, the Committee on Legislation has worked toward passage of the following state bills: (1) Revision of Medical Practice Act; (2) "Heart Bill"; (3) Sterilization; (4) Marriage Laws.

The revision of the Medical Practice Act was weakened somewhat by an osteopath-sponsored amendment

exempting "any person licensed by any other examining board," but was passed otherwise intact. The Heart Bill, which would have permitted employers to hire cardiacs without fear of liability under the Workmen's Compensation Law, died in committee after stiff opposition from plaintiff attorneys and organized labor. The Sterilization Bill was killed by strong opposition which developed in religious circles. The committee deemed it inadvisable to attempt the major campaign which would be necessary to gain passage of the marriage law amendment setting up a compulsory three day waiting period before issuing of marriage certificates.

During the 1957 session of the legislature, the committee became involved in opposition to an osteopath-sponsored bill to re-define the practice of osteopathy. Executive Committee was consulted and an opposition policy adopted because this bill in effect would allow full and unrestrained practice of medicine; this would be contrary to public good due to the fact that the osteopathic schools are below grade "B" medical school standards. This bill remained in subcommittee and will still be "alive" when the legislature meets in January 1958.

Other bills relating to medicine which were taken up during the session of the state legislature included:

(1) Hospital Care for the Indigent—This sets up the program to implement the recommendations of the Georgia Hospital Care Study Commission, but must await passage of appropriations.

(2) A bill permitting county boards of education to require vaccination against polio as a prerequisite for admission to school.

(3) A bill setting up a study commission to look into mental health problems in Georgia.

(4) A committee to study the possibility of using the old Piedmont Hospital buildings in Atlanta as a screening center.

(5) Establishment of a facility for Negro mentally deficient children at Gracewood.

(6) A bill to designate chiroprodists "participating physicians" under the non-profit Medical Service Act of 1950 failed to pass.

(7) A bill to provide scholarships for student nurses under the State Medical Education Board failed to pass.

(8) A bill relating to temporary licenses issued by the State Board of Medical Examiners failed to pass, but can be voted on again in 1958.

The committee met with key men from over the State in November to discuss with Dr. Alphin of the AMA Washington Office, means of implementation of national legislation. In December a dinner was held in Atlanta to entertain state legislators and present them MAG's views on pending legislation; a second dinner was given in Statesboro in January for the same purpose. In conjunction with the Georgia Heart Association, the committee, with other MAG representatives, met with legislators to work on support of the "Heart Bill". Several public hearings of the legislature held on various bills during the General Assembly were attended by members of the committee. This report would not be complete or entirely factual until proper credit has been given to Mr. John Kiser, who has borne the bulk of this committee's load in establishing contacts and coordinating our efforts in support of desirable medical legislation.

This committee has already recommended to Council that studies of the physician-osteopath relationship in the state be made and long range policies be adopted for guidance in considering future legislation that may be proposed. The committee further recommends that a program be worked out with the help of the various local societies to establish local contacts with the legislators throughout the year. Several societies have independently undertaken meetings with their state legislators for discussion of legislation; this contact at the local level carries far more weight of influence than the contacts made by MAG representatives during the rush of the General Assembly.

Reference Committee Recommendation—The report of the Legislation Committee accepted as information. I move the adoption of this section of the report.

House of Delegates Action—Adopted the Legislation Committee report as recommended by the reference committee on motion duly made and seconded.

Insurance and Economics Committee

DAVID R. THOMAS, JR., M.D., Augusta, *Chairman*

The work of this committee has continued this year accomplishing more than in the past two years because of the ground work that had been done. The scope of work is broader and new problems are coming before the committee. The meetings have been well attended and the members of the committee have been active in their efforts to accomplish the assigned tasks.

The cooperation of the Executive Committee has been excellent. Mr. Krueger, Mr. Kiser, and their staff have been active and interested in the important problems of the committee. They have visited the component societies presenting the insurance work that is being done in their behalf.

Again, John Elliott and Mr. H. B. Coolidge of Savannah have handled the unlisted procedures and the unusual cases that continue to come to the committee. This is a vital function of the committee, and their work on these cases must be carried on. All expenses in connection with this should be borne by the Medical Association of Georgia.

The work previously done so well by Mr. Lam Schultz of Chattanooga, Tennessee, Chairman of the Advisory Committee of the Health Insurance Council, has been taken over by Mr. Dick Jones of Greensboro, North Carolina. The work, counsel, and advice of these gentlemen are appreciated.

Professional Liability: The experience enjoyed by the Saint Paul-Mercury Indemnity Company has been favorable, and there has been a reduction in the premium that we are now paying and further reduction will be made at an early date. While we are experiencing this reduction in premiums, at the same time an increase in the premiums has been granted other companies.

In cooperation with Saint Paul-Mercury, a booklet was sent to each doctor in the state indicating the handling of any threatened professional liability claim. I must stress that the best way to prevent malpractice claims is to avoid these basic things that might cause them. The prevention of claims indicates that we can experience better patient-physician relations and also save financially.

Group Life Insurance: Our group life insurance program with the Provident Life and Accident Insurance Company continues in satisfactory operation. As

you know, any new member must participate within six months of becoming a member of the Medical Association of Georgia or he will have to show that he is insurable; for this reason, the executive secretary has been requested to furnish Provident with the names of new members as soon as such lists are available.

Group Health and Accident Insurance: The Group Health and Accident Insurance as carried by this Association continues to prove very valuable to our members. It has come to our attention that this type of insurance when written for the purpose of defraying regular business expenses, is a deductible expense as ruled by the Internal Revenue Department. However, when the premium is so deducted it also becomes accountable as income when the income is received, and taxes must be paid. This deserves the careful consideration of the subscriber of health and accident insurance.

The Georgia Plan: The Georgia Plan Insurance has been revised. The plan now includes optional medical and anesthesia fees that must be offered the subscribers. The fee schedules have been revised and are now much more realistic. We must remember that the service feature applies only for limited incomes and otherwise it is an indemnity policy.

Special consideration is given cases deserving consideration, and this is handled individually. There has, of course, been some dissatisfaction with some doctors, but I feel that the member of the committee working out the schedule of fees has done a big and worthwhile job.

Your support and participation in the plan are requested in order that we can make it more effective in our fight against socialized medicine.

Major Medical Insurance: The growth and popularity of major medical insurance has been phenomenal. It amounts basically to co-insurance with a basic deduction. This deduction varies and the capital amount is usually limited to five or 10 thousand dollars, with the insurance company paying 75 per cent of the expense and the insured 25 per cent of all cost above the basic deduction. The consideration of this in your insurance program is recommended to all of you for yourselves and certain selected patients.

Social Security Coverage (OASI): After much discussion and study the committee reluctantly unanimously passed and recommended to the Medical Association of Georgia Council that the membership of the Medical Association of Georgia be included under the present Social Security program. This was presented to the Medical Association of Georgia Council and they have referred it to the House of Delegates.

Reference Committee Recommendation—The Insurance and Economics Committee report is accepted for information with the following suggestions:

(1) Section on major medical insurance—reference committee recommends that the following be added: "That Council be empowered to act as it feels to be in the best interests of the Association on a recommendation of the Insurance and Economics Committee to be presented providing group extended coverage insurance for members of the Medical Association of Georgia."

(2) Social Security Coverage (OASI Title II)—reference committee recommends that action on the OASI report be deferred at this time pending the outcome of the Jenkins-Keogh Bill.

I move the adoption of this section of the report.

House of Delegates Action—Adopted Item 1 of the reference committee recommendation on the Insurance and Economics Committee report on motion duly made and seconded.

It was moved that Item 2 (Social Security Coverage) be tabled pending action by Reference Committees No. 1 and No. 4 on the same subject. (See page 299). This motion was approved.

Constitution and By-Laws Committee

THOMAS W. GOODWIN, M.D., Augusta, *Chairman*

Insofar as the report of the Committee on Constitution and By-Laws is concerned, you may make the following report: The Constitution and By-Laws Committee has only had one informal meeting this year and that was by mail. It was felt that since so much work had been done last year that very few changes in the Constitution and By-Laws were needed. The following changes, however, are recommended:

Chapter I, Section 1. Membership. It is recommended that this section be changed as follows so that it now reads: Section 1. A physician holding the degree of Doctor of Medicine or Bachelor of Medicine from a medical college acceptable to the Council of the Association, licensed to practice medicine in the State of Georgia, who is a citizen of the United States and who has not been judged guilty of moral turpitude or other serious crime, may be eligible for membership after being certified by the secretary of a component society as being a member in good standing of said component county society.

Chapter IV, Section 3. Executive Committee. Let the following paragraph be inserted following the sentence "It shall meet monthly between the meetings of Council". At any duly called meeting of this committee for which proper notice has been given, any three (3) members of the committee shall constitute a quorum.

Chapter X, Section 1. Special Committees. Add to Section 1, such special committees shall be appointed annually.

Reference Committee Recommendation—The Constitution and By-Laws Committee report was accepted for information and it was moved that their recommendations be accepted with the following addition to Chapter X, Section 1—Special Committees, so that the sentence shall read as follows: "Such special committees shall be appointed annually, and their terms of office shall run concurrently with those of the appointing president." I move the adoption of this section of the report.

House of Delegates Action—Adopted the Constitution and By-Laws Committee report as recommended and altered by the reference committee on motion duly made and seconded.

Advisory Committee to the Woman's Auxiliary

E. M. DUNSTAN, M.D., Atlanta, *Chairman*

This committee met with the Executive Board of the Woman's Auxiliary on June 29, 1956, at which time plans for the year's work were outlined. A comprehensive and well thought out program, without any controversial items, was presented, adopted, and has been implemented throughout the year.

Since this time, members of the committee have been consulted informally throughout the year, and have given advice as indicated.

We wish to thank the Woman's Auxiliary for their serious-minded, intelligent, and sustained efforts in behalf of our Association. These devoted women are in truth in the front line of our public relations program.

Reference Committee Recommendation—We accept the report of the Advisory Committee to the Woman's Auxiliary to the Medical Association of Georgia and commend the members of

this committee. I move the adoption of this section of the report.

House of Delegates Action—Adopted the Advisory Committee to the Woman's Auxiliary report as recommended by the reference committee on motion duly made and seconded.

Crawford W. Long Memorial Committee

LESTER RUMBLE, JR., M.D., Atlanta, *Chairman*

On behalf of your committee, and, incidentally, the citizens of Jefferson, Georgia, we are delighted to report that the Crawford W. Long Museum should be completed and ready for dedication by the summer of 1957.

The framework of the building in Jefferson was completed in 1956, and its completion represented the expenditure of the final sum of \$25,000.00 given this group by former Governor Talmadge. During the year 1956 we received a promise of a \$30,000.00 additional budget, which was placed in the bank for our use in January of 1957. Most of the contracts for the art work have been let, and completion is anticipated within six months.

The plans for the year 1957 include the dedication ceremony, and our major problems will consist in being able to assume the responsibility of the completed museum, which was our agreement with the Historical Commission at the inception of this idea.

You are cordially invited to view the museum and the progress being made therein at any time you happen to be within the vicinity of Jefferson.

Reference Committee Recommendation—The Crawford W. Long Memorial Committee report is accepted as information, and reference committee commends this committee for their excellent work. I move the adoption of this section of the report.

House of Delegates Action—Adopted the Crawford W. Long Memorial Committee report as recommended by the reference committee on motion duly made and seconded.

American Medical Education Foundation Committee

BEN K. LOOPER, M.D., Canton, *Chairman*

The American Medical Education Foundation Committee got off to a late start in November of 1956, and shortly after its formation a letter was mailed to all the members of the Medical Association of Georgia, just before Christmas. The response was good and our December donations to AMEF totaled \$1,415.00—our largest month to date. However, we received only \$35.00 in October—and \$90.00 in November—so we can still afford to be generous.

Our total contributions to date (March 1st) amount to only \$3,331.00 and since our goal for 1956-57 is \$10,000.00, we are just \$6,669.00 short as we go into the home stretch.

We plan to mail only *one* more letter to the membership and two card followups—and since we received only \$90.00 in January and only \$200.00 in February, we are still \$6,379.00 under par. As it is near tax time we hope to receive larger donations in both March and April—remember all donations to AMEF are tax deductible—cash in before it is too late.

1955—Just for the record the medical schools of Georgia received in 1955 \$55,850.52 from AMEF, and the National Fund (\$27,557.00 to the Medical College of Georgia and \$28,265.52 to Emory Medical School), and we as physicians contributed only \$7,336.14. Of this amount, AMEF gave to Georgia \$1,562.00, so Georgia doctors contributed actually only \$5,774.14.

1956—In 1956 we received from AMEF and the National Fund \$72,640.00; \$6,850.00 from AMEF to Emory medical School and \$6,850.00 from AMEF to Georgia Medical College a grand total of \$86,340.00 last year for medical education in Georgia. The physicians of Georgia contributed only \$3,240.00, \$1,659.00 earmarked for the Medical College of Georgia and \$1,583.00 for Emory Medical School, and the ladies of the Medical Auxiliary, "God love 'em," also gave \$1,594.00 to AMEF for 1956.

1957—Again, I would like to repeat that our goal for 1956-57 is only \$10,000.00—we need a total of \$6,379.00 before May 1st. Doctors, do not delay any longer, the medical schools who have helped you throughout your lifetime need your help now. Send your contributions soon if you have not already done so—to *The American Medical Education Foundation*, 535 North Dearborn Street, Chicago 10, Illinois. Remember—it is tax deductible!

We will need \$300.00 to carry out our mailings to the medical profession of Georgia and we respectfully request that this amount be granted to us immediately so that we may complete our campaign.

Reference Committee Recommendation—We accept the report of the American Medical Education Foundation Committee for information and commend the members of this committee. I move the adoption of this section of the report.

House of Delegates Action—Adopted the AMEF Committee report as recommended by the reference committee on motion duly made and seconded.

The Journal

EDGAR WOODY, JR., M.D., Atlanta, *Editor*
MISS FRANCES H. PORCHER, *Managing Editor*

The 1956-57 report of the *Journal of the Medical Association of Georgia* is submitted herewith.

Personnel—David Henry Poer, Secretary-Treasurer of the MAG, submitted a letter to the Council, dated November 15, 1956, requesting he no longer be designated as editor-in-chief after January 1, 1957, but that he remain chairman of the Publications Committee. This recommendation was approved by Council.

The Contributing Editors are the same as this time last year and are continuing to carry out the functions of their office admirably. They are as follows: Herbert S. Alden, Atlanta; Thomas Findley, Augusta; J. Willis Hurst, Atlanta; Charles S. Jones, Atlanta; Arthur M. Knight, Jr., Waycross; Arthur J. Merrill, Atlanta; Lester Rumble, Jr., Atlanta; Peter L. Scardino, Savannah; Patrick C. Shea, Jr., Atlanta; Henry H. Tift, Macon; and Robert H. Vaughan, Columbus.

Ted F. Leigh, Emory University, photography editor, has continued to supply us with excellent cover photographs, and Miss Thelma Franklin handles the *Journal's* business matters with her usual acumen.

In the spring of 1956 the decision was made to change printers, and beginning with the June 1956 issue Higgins-McArthur Company has printed the *Journal*. Mr. John Stuart McKenzie, that company's representative, has long been our typography consultant, and it is our sincere belief that this change has been beneficial and that the *Journal* printing is now superior in many respects to what it used to be.

Award—On September 28, 1956, the *Journal of the Medical Association of Georgia* was presented the 1956 American Medical Writer's Association Honor Award

for Distinguished Service in Medical Journalism, Class 1-B (general medical publications with less than 3,000 circulation). Edgar Woody, Jr., Editor, and Miss Frances Porcher, Managing Editor, were in Chicago for the 13th Annual Meeting of the AMWA, and Dr. Woody received the Award for the *Journal* at the annual banquet. The citation for the Award reads as follows: "For accuracy, clarity, conciseness and newness of information; for excellence of design, printing, and illustrations, and for distinguished service to the medical profession."

Conference—On November 3 and 4, 1956, the *Journal of the Medical Association of Georgia* sponsored the Southeastern State Medical Journal Conference at the Academy of Medicine in Atlanta. In attendance were 35 representatives of 13 state journals and one county bulletin from the Southeast and surrounding states. The journals represented were those of the following states: Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Missouri, North Carolina, Oklahoma, South Carolina, Texas, and Virginia. The Bulletin was the *Fulton County (Georgia) Medical Society Bulletin*. Special guests were Mrs. Adelaide K. Davis, Mr. Alfred J. Jackson, and Mr. Earl A. Sorensen, of the State Medical Journal Advertising Bureau, Chicago.

Edgar Woody presided at all sessions, and Hal M. Davison and David Henry Poer welcomed the participants on behalf of the Association. Guest speakers at the meeting were Austin Smith, Chicago, Editor of the *Journal of the American Medical Association*; Mr. Otto M. Forkert, Chicago, President of O. M. Forkert and Associates, Typography and Graphic Arts Consultants; Mr. John S. McKenzie, Atlanta, Typography consultant with Higgins-McArthur Company; Ted F. Leigh, *Journal* Photography Editor; Mrs. Ethel M. Liebscher, Atlanta, Director of Research and Assistant to the President of Burke Dowling Adams, Inc., advertising agency; and Mr. Albert Beehler, Baltimore, Vice-President of Waverly Press. On Saturday night, de Leon Laboratories of Atlanta, Mr. Harold C. Palmer, President, sponsored a social hour and dinner for all conference participants and guests at the Piedmont Driving Club. This is the first such regional conference for state medical journals ever held; if demand warrants a repeat performance, there will be another in 1958.

Content—There have been four noteworthy changes in content in the past year: (1) The roster of the Woman's Auxiliary to the Medical Association of Georgia was published as a separate booklet in August and sent to all the members of the Auxiliary. Heretofore, the Auxiliary roster was published in the MAG roster and was not sent to all Auxiliary members since the Association roster is published as a *Journal* supplement and goes only to active MAG members, advertisers and subscribers. We feel that this is a giant step forward in getting information to the people who have use for it and keeping it from going to those who have no use for it.

(2) Publication of a "Legal Counsel Page" was instituted in November 1956. Articles by Mr. John A. Dunaway, MAG Legal Counsel, on medicolegal problems, appeared in the November and December, 1956, and February, 1957, issues and will continue to be published as they are received.

(3) The character of the "President's Page" has changed somewhat in the past year. Dr. Davison has written meaningful, longer articles on the problem of the corporate practice of medicine which have been published every three months, instead of writing a short message each month.

(4) Publication of a "Mental Health Page" was approved by the editor and Publications Committee, and one such page was printed in April 1956.

Typography and Format—Minor changes have been made from time to time during the past year, but no drastic departures from the norm have been effected. In the March 1957 issue a plan of rotating colors used on the cover was instituted. We feel that this will add interest and life to future issues, and it will make it easier to distinguish one month's issue from another.

Equipment—With the approval of Council, a Polaroid Land Camera was purchased for use by Association personnel to illustrate reports of happenings around the state; new officers, meetings, etc.

Summary—We have been gratified in the past year to have been quoted in many other medical publications, newspapers, by the Public Relations Department of the AMA, and most recently a nationally syndicated column on health, written for lay consumption, was based on a *Journal* article. The article quoted was by a Georgia author.

Typographically, we were given a very complimentary rating at the Southeastern State Medical Journal Conference. All of this seems to indicate that what we have been trying to accomplish is being favorably looked upon and encourages further progress.

Recommendations—(1) That a readership survey be carried out by a professional survey taker. (2) That the MAG sponsor a biennial meeting such as was held in Atlanta in November from henceforth if the other participants in the conference concur in the value of such a meeting.

Reference Committee Recommendation—We recommend the approval of the report of the *Journal of the Medical Association of Georgia* for information, and highly commend the editor and staff. Their excellent work is recognized in their having received the Medical Writers' Association Honor Award for Distinguished Service in Medical Journalism, Class 1-B, 1956. This committee recommends that a "readers' survey," as recommended in this report, be carried out by a professional survey taker when funds are available and Council approves such a survey. The committee also recommends biennial meetings as recommended in the report and at the discretion of Council. I move the adoption of this section of the report.

House of Delegates Action—Adopted the *Journal* report as recommended and altered by the reference committee on motion duly made and seconded.

Woman's Auxiliary to the Medical Association of Georgia

MRS. WALKER L. CURTIS, College Park, *President*

Benjamin Franklin said, "Time is the staff life is made of." The year 1956-57 though a joyous one, has seemed rather short on TIME. For the President of the Woman's Auxiliary, the days have been motivated and regulated by the clock and the calendar and the meeting of appalling "deadlines."

In keeping with the spirit and aims of the doctors whom the Auxiliary is definitely organized to "aid and abet," the main objectives of the administration have centered around Community Health leadership

and sponsorship. Members have held office in local organizations, given health programs, established speakers' bureaus, headed health committees and numerous health drives. Not only have these activities proven worthwhile within themselves, but have served as a strong factor in Public Relations by building up a fuller and more sympathetic understanding between the doctor and the public which he strives so faithfully to serve.

Recruitment for medical careers continues to be a special project. The cause of nursing has been presented to graduating classes of most of Georgia's High Schools. Future Nurses' Clubs are being sponsored by Auxiliaries. One county is now sending two nurses through training school. Another Auxiliary sponsored a speech clinic for Nurse Recruitment, and a GEMS (Good Emergency Mother Substitute), Baby Sitters' Course.

The William R. Dancy, M.D. Student Loan Fund, designed for the assistance of medical students, has been increased. Around a thousand dollars has been contributed to the American Medical Education Foundation. *The Auxiliary News*, issued quarterly, has been an informative tie, correlating the work of State and County Auxiliaries. *Today's Health* and the *Bulletin*, official organs of the American Medical Association and its Auxiliary, have had increased subscriptions.

The observance of Doctors' Day, March 30th, has been statewide, and has not only aided in bringing about a more doctor-conscious public, but has been the occasion of much fraternal fellowship and relaxation among the doctors themselves. Contributions of real value have been made through the Research and Romance of Medicine.

Civil Defense, safety measures and legislation pertaining to health bills are being studied and stressed through letters and lectures, school programs, motion pictures and slides. One of the most outstanding and educational projects sponsored by a County Auxiliary, in conjunction with its medical society, was a Cavalcade of Medicine, viewed during its three-day presentation by approximately 20,000 persons, including 3,000 students representing 17 high schools.

Cerebral Palsy Schools, Mental Health and Child Guidance Centers, Cancer Clinics and Schools for Exceptional Children are being sponsored through gifts and by hours of service. Members have personally assisted in giving blood tests, chest x-rays, polio shots, eye and ear tests and blood donations.

One new Auxiliary has been added to the State Roll of County Auxiliaries, and cordial welcome is extended the Woman's Auxiliary to the Spalding County Medical Society, which, though very young, is showing vigorous growth. County Auxiliaries within the State now number 40, comprised of 89 counties, with an approximate membership, including members-at-large, of 1,530.

Four well-attended Executive Board meetings have been held, with Dutch luncheons featuring each meeting. These periods of fellowship have been the occasion of establishing friendship among these like-minded women that will be a joy through years to come. The June Board meeting was held in Atlanta with the Advisory Committee from the Medical Association of Georgia as special guests. Statewide plans were discussed and placed before the members of this committee and were stamped with their approval. To this Committee, consisting of Dr. Edgar Dunstan, Chairman, Dr.

Shelley C. Davis, and Dr. Leo Smith, the deep appreciation of the President and the entire Auxiliary is expressed for its wise advice and ever helpful consideration.

Twenty-nine district and County Auxiliary meetings have been attended by the Auxiliary President this year, and 11 attended last year. Speeches have been made or discussions led on all of these occasions. Articles have been written regularly for the *Auxiliary News*, from letters, and various types of Auxiliary literature have been prepared for mimeographing and mailing, innumerable personal letters have been written, and the telephone has been talked completely out of commission.

The State Auxiliary has been represented, by its President, at uncounted meetings of health and civic organizations. Meetings outside the State that have been attended are: AMA Auxiliary Conference for Presidents held in Chicago; AMA Auxiliary Convention, also in Chicago; and the Convention of Woman's Auxiliary to the Southern Medical Association in Washington, D. C. (at which time, the Georgia Auxiliary President was made President Elect of the Southern Auxiliary). More than 6,000 miles have been traveled within the State, and approximately 4,000 miles outside the State.

The Auxiliary is greatly indebted to Mr. Milton Krueger and to the full staff of the Medical Association of Georgia office for much needed assistance in mimeographing and mailing out of minutes, form letters and other official communications to local organizations.

Acknowledgment and deep appreciation are extended to Dr. Hal M. Davison, President, for his continuous interest and timely encouragement. Further acknowledgment and sincere thanks are expressed to the Medical Association of Georgia for the financial support that helped make possible the attendance of the President and President-Elect upon the AMA Auxiliary Conference held in Chicago, for defraying the expense of publishing the *Auxiliary News* and the Annual Reports, and for printing the membership Directory—the first Directory, completely its own, the Auxiliary has had.

Grateful recognition is extended Auxiliary officers and members for the abiding patience, unswerving loyalty and energetic cooperation that have characterized the year, filling it with effort and crowning it with success.

Reference Committee Recommendation—The report of the Woman's Auxiliary to the Medical Association of Georgia was received and accepted for information. This committee feels that words cannot express the appreciation to the president and members of the Auxiliary for the untiring and tremendous amount of work that they have done in our behalf. We wish to commend this organization and its numerous activities to the very highest. "God bless them all." I move the adoption of this section of the report.

House of Delegates Action—Adopted the Woman's Auxiliary report as recommended by the reference committee on motion duly made and seconded.

Resolution No. 1 Radiology

WILLIAM C. COLES, M.D., Atlanta

BE IT RESOLVED that, since the Medical Association of Georgia recognizes the practice of radiology as a medical specialty, all fee schedules for examination and therapy be included in the Medical Care Policies. and not in the Hospital Care Policies.

BE IT FURTHER RESOLVED that the Medical Association of Georgia through its House of Delegates recommend a complete medical care insurance program, included the fees for x-ray examination and therapy.

Reference Committee Recommendation—Resolution No. 1 on Radiology—This resolution was changed to include radiology, pathology, anesthesiology, and physical medicine and read:

"BE IT RESOLVED that the Medical Association of Georgia recognize the practice of radiology, pathology, anesthesiology, and physical medicine as medical specialties, that all fee schedules for examination and therapy be included in the Medical Care Section and not in the Hospital Care Section of policies.

BE IT FURTHER RESOLVED that the Medical Association of Georgia, through its House of Delegates, recommends a complete medical care insurance program including the fees for x-ray examinations, therapy, and the use of radioactive isotopes in examinations and treatment of patients."

I move the adoption of this report.

House of Delegates Action—Adopted Resolution No. 1, on radiology, as recommended and altered by the reference committee on motion duly made and seconded.

Resolution No. 3 Anesthesia, Radiology, Pathology, inclusion in "Medicare"

J. FRANK WALKER, M.D., Atlanta

WHEREAS, the Medical Association of Georgia has declared that the practices of anesthesiology, pathology, radiology, and physical medicine are practices of medicine, and

WHEREAS, anesthesiologic, pathologic, radiologic and physical medical services may be rendered in or outside a hospital, and

WHEREAS, such anesthesiologic, pathologic, radiologic, and physical medical services can be performed only by or under the supervision of duly licensed physicians, and

WHEREAS, the Medical Association of Georgia has contracted for the physicians of the State of Georgia with the Department of Defense to supply medical services to dependents of the Uniformed Forces under Public Law 569 of the 84th Congress, (otherwise known as the *(Dependents' Medical Care Act)*, and

WHEREAS, certification of medical services rendered can be made only by physicians,

THEREFORE BE IT RESOLVED that the Medical Association of Georgia hereby declares that anesthesiology, pathology, radiology, and physical medicine are practices of medicine, under the terms of the contract which has been negotiated between the Medical Association of Georgia and the Department of Defense, as set forth in Contract No. DA-49-007-MD-812, dated November 30, 1956, issued by the Department of Defense in compliance with the Dependents' Medical Care Act, and fees for such services, wherever rendered, must be paid to the physicians rendering the services.

BE IT FURTHER RESOLVED, that the Medical Association Delegates to the AMA present a similar resolution to the House of Delegates of that organization requesting that similar action be taken by the AMA.

Reference Committee Recommendation—Resolution No. 3, on Anesthesiology, Radiology, Pathology, and Physical Medicine inclusion in "Medicare." We recommend the adoption of the resolution. I move the adoption of this section of the report.

House of Delegates Action—Adopted Resolution No. 3, on Anesthesiology, Radiology, Pathology, and Physical Medicine inclusion in "Medicare," as recommended by the reference committee on motion duly made and seconded.

Resolution No. 8

Blue Shield—Blue Cross Plans

THOMAS-BROOKS MEDICAL SOCIETY DELEGATION

WHEREAS, the House of Delegates of the Medical Association of Georgia represents the medical profession in Georgia, and

WHEREAS, the medical profession of Georgia is vitally interested in the many voluntary health insurance plans, and

WHEREAS, Blue Shield-Blue Cross voluntary plans are the direct responsibility of the medical profession in that they are advertised as "The Doctor's Plans," and

WHEREAS, there has not been a thorough study on a national level of these organizations, since their maturity, by the profession itself, and

WHEREAS, these organizations have had criticism in the press and by physicians over the nation;

THEREFORE BE IT RESOLVED that the House of Delegates of the Medical Association of Georgia feels that, in the light of changing economic conditions, an investigation of Blue Shield-Blue Cross policies are in order.

BE IT FURTHER RESOLVED that the House of Delegates of the Medical Association of Georgia request that a special committee from the House of Delegates of the American Medical Association be appointed by the Speaker of the House, conduct a thorough study of the plans, contracts, policies, and other agreements of these organizations in reference to physician-patient relationship, physician-hospital relationship, and discrimination, if any, in contracts to patients, to physicians and to hospitals. This study to be on a national level, and

BE IT FURTHER RESOLVED that the special committee of the American Medical Association be requested to make a full report of their study and recommendation to the House of Delegates of the American Medical Association at their annual meeting in June 1958.

(Adopted by the Thomas-Brooks Medical Society March 21, 1957.)

Reference Committee Recommendation—Resolution No. 8, on Blue Shield-Blue Cross Plans. We recommend approval of this resolution with the following changes: in the third paragraph, delete the portion which reads, "in that they are advertised as 'the doctors plan'." Substitute the words "a study and survey" for "an investigation" in the sixth paragraph. I recommend the adoption of this section of the report.

House of Delegates Action—Adopted Resolution No. 8, on Blue Shield-Blue Cross Plans, as recommended and altered by the reference committee on motion duly made and seconded.

Resolution No. 13

Practice of Medicine

W. A. FULLER, M.D., Augusta

RESOLVED, that the practice of pathology, anesthesiology, roentgenology, and physical medicine is the practice of medicine as defined, or understood, in the State of Georgia.

Reference Committee Recommendation—Resolution No. 13, on Practice of Medicine. No action necessary on this resolution as the contents of this resolution were taken care of in Resolution No. 1. I recommend the adoption of this section of the report.

House of Delegates Action—Adopted the action of the reference committee in regard to Resolution No. 13, on Practice of Medicine, on motion duly made and seconded.

Resolution No. 15

Standardization of Health Insurance Forms

JOHN B. O'NEAL, M.D., Elberton

WHEREAS, much time and effort is required to complete the ever increasing number of blanks, forms, etc., necessary to facilitate payment of insurance claims, and

WHEREAS, this results in an increasing amount of secretarial assistance which a physician has to supply at his expense,

THEREFORE BE IT RESOLVED that the Elbert County Medical Society by unanimous vote requests that Council appoint a committee to study and present to them within six months a standardized insurance claims blank acceptable to all insurance companies licensed in the State of Georgia and that Council take the necessary steps to have this plan adopted through available channels. To the end sought it is urgently requested that the matter be handled as quickly as possible.

Reference Committee Recommendation—Resolution No. 15, on Standardization of Health Insurance Forms. This resolution was withdrawn by the author, J. B. O'Neal, due to its similarity to Resolution No. 17. I recommend the adoption of this section of the report.

House of Delegates Action—Adopted the action of the reference committee on Resolution No. 15, on Standardization of Health Insurance Forms, on motion duly made and seconded.

Resolution No. 16

American Medical Education Foundation

BIBB COUNTY MEDICAL SOCIETY

WHEREAS, the American Medical Education Foundation is a foundation dedicated to aiding our medical schools in defraying the ever-rising costs of medical education, and

WHEREAS, physicians themselves must contribute in order to assure the success of this program, without government interference in medical education, and

WHEREAS, the Sixth District Medical Society in regular session at Macon, Georgia, on December 5, 1956, voted to recommend to the House of Delegates of the MAG that the annual dues of the Association be increased \$5.00 over the present amount and that this money be given each year to the AMEF,

THEREFORE BE IT RESOLVED that the annual dues of the Association be increased \$5.00 beginning January 1, 1958, and that all money received as a result of this increase be donated annually by the Association to the AMEF.

Reference Committee Recommendation—Resolution No. 16, on AMEF. We recommend the disapproval of this resolution with the following explanation: it is felt that each member of the Medical Association of Georgia should be impressed with his duty to contribute to this fund, but we do not feel that this should be a compulsory contribution at this time. I move the adoption of this section of the report.

House of Delegates Action—Adopted the action of the reference committee concerning Resolution No. 16, on AMEF, on motion duly made and seconded.

Resolution No. 17

Standardization of Insurance Forms

JOSEPH B. MERCER, M.D., Brunswick

WHEREAS, the time of the practicing physician is becoming more and more premium as he is called on to do more and more paper work, and

WHEREAS, much of this theft of time is brought about either directly or indirectly by demands of Insurance Companies, and

WHEREAS, most insurance forms ask for the same information but in different numerical sequence making carbon copies impossible, and

WHEREAS, the Georgia Hospital Association has had the same problem and has solved it by adopting standard forms, and other state medical associations have solved it similarly, and

WHEREAS, the Medical Association of Georgia feels that every effort should be made to assist the individual physician to find more time for the practice of medicine, pursuit of family life and recreation, and the Insurance Committee of this organization has not completed action reportedly begun over two years ago,

THEREFORE BE IT RESOLVED that the House of Delegates instruct the Council of the Medical Association of Georgia to name immediately a special committee on standardization of insurance forms with directions to investigate the problem and cooperating with the insurance companies in Georgia produce a standard form for: (1) surgical; (2) medical, or (3) a combination of these, and (4) weekly "sick blanks." This committee shall present its recommended forms to the Council within 60 days and Council is instructed to initiate action toward adoption of this form at once.

Reference Committee Recommendation—Resolution No. 17, on Standardization of Insurance Forms. We recommend the approval of this resolution. I move the adoption of this section of the report.

House of Delegates Action—Adopted resolution No. 17, on Standardization of Insurance Forms, as recommended by the reference committee on motion duly made and seconded.

Resolution No. 19 The Medicare Program

FRANK B. SCHLEY, M.D., Columbus

WHEREAS, the operation of the Medicare Program by the central Headquarters Office of the Medical Association of Georgia has resulted in criticisms of the Medical Association of Georgia because of delays in processing forms, and

WHEREAS, the continuation of the program by the Association of Georgia will cause disharmony and dissatisfaction within the organization and may interfere with the efficient performance of the many other duties and services usually provided by the Headquarters Office staff, and also no financial gain will accrue to the Association,

THEREFORE BE IT RESOLVED that the Council of the Medical Association of Georgia be requested to study the operation of the program taking these facts into consideration, and to explore the possibility and desirability of sub-contracting the fiscal management to Blue Shield or a similar organization performing this type of insurance business.

(Resolutions No. 19 and the following No. 21 were so similar in content that they were acted on jointly as noted after Resolution No. 21.)

Resolution No. 21 Medicare

CHARLES R. ANDREWS, M.D., Canton

WHEREAS, The Council of the Medical Association of Georgia rightly and properly assumed the respon-

sibility for the complete management and operation of the Medicare program when the contract was made available by the Defense Department of the Federal Government, and

WHEREAS, the operation has caused a serious strain on the facilities of the headquarters office of the Medical Association of Georgia, and

WHEREAS, this has brought criticism of the personnel of the Headquarters Office of the Medical Association of Georgia, and

WHEREAS, sufficient experience has been obtained to indicate that this work will increase and continue to be an administrative problem,

THEREFORE BE IT RESOLVED that the House of Delegates direct Council to study this problem and subcontract the fiscal portion of this work to Blue Shield or a similar organization if such seems to be desirable.

Reference Committee Recommendation—Resolution No. 19, on Medicare Program, and Resolution No. 21, on Medicare. We recommend not approving these two resolutions and offer the following substitute resolution:

"WHEREAS, the operation of the Medicare Program by the central Headquarters Office of the Medical Association of Georgia presents many problems, and

"WHEREAS, the program has been in operation for so short a time that it is difficult to evaluate the administration of this program,

"THEREFORE BE IT RESOLVED that the Medicare program be continued in its present form until a more adequate evaluation of this program has been obtained."

I move the adoption of this recommendation.

House of Delegates Action—Adopted the reference committee recommendation to disapprove Resolutions No. 19 and No. 21 and to approve the reference committee substitute resolution on motion duly made and seconded.

Resolution No. 20 Provision for Tax Deduction for Treating Medically Indigent

JOHN B. O'NEAL, M.D., Elberton

WHEREAS, in the 1957 Session of the Georgia Legislature the Medical Association of Georgia co-sponsored two bills which authorized payment of hospital bills for the indigent and those receiving old-age assistance, and

WHEREAS, this legislation was sponsored with intent for the physicians treating these patients to donate their services, and

WHEREAS, members of the Medical Association of Georgia are willing to accept this service as a part of their obligation, and

WHEREAS, the members of the Medical Association of Georgia wish some recognition of this service in their tax reports,

THEREFORE BE IT RESOLVED that the Elbert County Medical Society request that Council appoint a committee to prepare and pass legislation that would enable such a physician to deduct from his state and federal income tax an average amount equal to the usual charge for services rendered for these patients. Such fees shall be based on the fees recommended in the Georgia Plan and/or the Blue Shield fee schedule.

Reference Committee Recommendation—Resolution No. 20, on Provision for Tax Deduction for Treating Medically Indigent. It is recommended that resolution be adopted with the following changes in the last paragraph: substitute the word "advocate" for the word "pass." I move the adoption of this section of the report.

House of Delegates Action—Adopted Resolution No. 20, on Provision for Tax Deduction for Treating Medically Indigent, as recommended and altered by the reference committee on motion duly made and seconded.

Resolution No. 22

David Henry Poer, M.D.

C. F. HOLTON, M.D., Savannah

WHEREAS, David Henry Poer has signified his intention of not standing for re-election as secretary-treasurer of the Medical Association of Georgia, an office he has held for six continuous years, and

WHEREAS, no one who has not served as an officer of this Association can possibly realize the tremendous amount of work this office requires, and

WHEREAS, Dr. Poer, during his tenure of office, has given unstintingly of his time and talents, and as a result he has placed the Medical Association of Georgia on a very sound professional, ethical, business, and financial plane. We have, indeed, been extremely fortunate in having him in this position during the times we have had confront us in the past.

THEREFORE, BE IT RESOLVED that the House of Delegates of the Medical Association of Georgia, in due meeting assembled in Savannah, Georgia, this the 28th day of April 1957, go on record as expressing our profound thanks and appreciation to Dr. Poer for the wonderful and dedicated services he has performed;

AND BE IT FURTHER RESOLVED that the House of Delegates of the Medical Association of Georgia request the Council of said Association to take the necessary steps to procure a suitable memento or trophy to be presented to David Henry Poer in the name of the Medical Association of Georgia by the president of said Association at a time and place deemed suitable by the president of the Association. This to be in recognition of Dr. Poer's outstanding service to the Association.

Reference Committee Recommendation—Resolution No. 22, on David Henry Poer. We wish to recommend the adoption of this resolution. I move the adoption of this section of the report.

House of Delegates Action—Adopted Resolution No. 22, on David Henry Poer, as recommended by the reference committee duly made and seconded.

On motion duly made and seconded it was moved the adoption of the report as a whole with certain amendments noted. This motion was approved.

Report of Reference Committee
No. 3

Rafe Banks, Jr., Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 3 met at 8:00 a.m., April 29, in Room 240, Hotel DeSoto, Savannah, with the following members present: Rafe Banks, Jr., Chairman; A. J. Waters, Augusta; Glenn E. Seymour, Albany; J. Frank Walker, Atlanta; C. F. Hol-

ton, Savannah; A. G. LeRoy, Thomson; J. A. Green, Athens, Secretary; Charles G. Green, Waynesboro; Frank B. Schley, Vice-Chairman, Columbus; and George L. Mitchell, Decatur.

Seventh District Councilor

D. LLOYD WOOD, M.D., Dalton

The Seventh District Medical Society holds two annual meetings which are quite well attended, and each year the quality of the scientific papers improves.

The county societies are functioning and membership is increasing as new doctors come into the district.

Due to circumstances the Seventh District Councilor has been unable to fulfill his duties as well as he should. Dr. Ralph Fowler, the vice-councilor, has very ably performed in the absence of the councilor.

Counties and Secretaries	Members December 31, 1956		Members December 31, 1955	
	MAG	AMA	MAG	AMA
Bartow				
A. L. Horton, Cartersville	9	6	8	8
Carroll-Douglas-Haralson				
D. S. Reese, Carrollton	33	19	35	21
Chattooga				
Wm. R. Thompson, Summerville	6	6	7	7
Cobb				
Fred Schmidt, Marietta	59	50	44	39
Floyd				
A. V. Gafford, Rome . .	56	49	54	46
Gordon				
Byron H. Steele, Fairmont	11	9	12	10
Polk				
John McGehee, Cedartown	13	9	17	10
Walker-Catoosa-Dade				
E. M. Townsend, Ringgold	28	18	31	22
Whitfield				
Lloyd C. Yeargin, Dalton	27	15	20	13
	242	181	228	176

Reference Committee Recommendation—The report of the Seventh District Councilor is approved.

House of Delegates Action—Adopted the report of the Seventh District Councilor as recommended by the reference committee on motion duly made and seconded.

Seventh District Vice-Councilor

RALPH W. FOWLER, M.D., Marietta

The Seventh District has had a very good year. We had two meetings held in Rome and Dalton in April and September, both well attended.

As Vice-Councilor, I have attended two Council meetings, one in Augusta and the other in Brunswick, both of which our Councilor, Lloyd Wood, was unable to attend. I have cooperated with the state office in setting up meetings of the local doctors with the local legislators and senator to promote medical interest in the recent legislature. I also took our Cobb County representatives and senator to a Medical Association of Georgia-sponsored meeting in Atlanta.

I have collaborated with the Seventh District secretary, Dr. Elliott of Cedartown, in arranging programs for the district meetings, and also worked with the Cobb County Medical Society in planning and presenting the Cavalcade of Medicine which was such a unique and successful program that it has aroused national interest and recognition. Its merits were strong in education and public relations for the medical profession.

As a whole the Seventh District is actively interested in organized medicine.

Reference Committee Recommendation—The report of the Seventh District Vice-Councilor is approved.

House of Delegates Action—Adopted the report of the Seventh District Vice-Councilor as recommended by the reference committee on motion duly made and seconded.

Eighth District Councilor

F. G. ELDRIDGE, M.D., Valdosta

The Eighth District Medical Society had a gain of five (5) members over 1956 and 10 as compared to 1955.

Valdosta, Waycross (Ware County), and Brunswick (Glynn County) continue to increase in population.

Several new hospitals have been constructed.

The district meetings were fairly well attended.

Due to the Councilor's newness to the position and the numerous meetings of Council as a result of the "Medicare" (Public Law 569) Program, he has been unable to visit the sectional society meetings as much as desired.

Next meeting of the Eighth District will be at Jekyll Island Hotel, April 12, 1957, 2 p.m.

Counties and Secretaries	Members December 31, 1956		Members December 31, 1955	
	MAG	AMA	MAG	AMA
Altamaha				
J. B. Brown, Jr., Baxley .	7	7	7	7
Coffee				
Horace Joiner, Douglas .	15	7	15	8
Glynn				
E. C. Kane, Brunswick .	34	28	34	29
South Georgia				
Lloyd Burns, Valdosta .	50	42	45	40
Telfair				
D. B. McRae, McRae . .	9	7	9	7
Ware				
A. M. Knight, Waycross .	47	40	46	36
Wayne				
D. H. G. Glover, Jesup .	8	8	9	7
	170	139	165	134

Reference Committee Recommendation—The report of the Eighth District Councilor was approved.

House of Delegates Action—Adopted the Eighth District Councilor report as recommended by the reference committee on motion duly made and seconded.

Ninth District Councilor

CHARLES R. ANDREWS, M.D., Canton

The Ninth District continues to be a strong and active district society, meetings are regularly held in April and September of each year and scientific programs are given much thought with regard to variety and content. These meetings are all well attended and there is excellent cooperation among all members of the district.

There still remain a few weak spots which should be improved particularly with regard to a few of the societies meeting more regularly and entertaining more serious consideration concerning medical affairs in general. Also, it still might be well for a few of the minimum member societies to combine and have more active meetings.

The Ninth District has changed its Selective Service Board Committee to have the executive officers head of the board, and they, in turn, will take up consideration with regard to selective service with the local society concerned.

Active membership in the Ninth District Medical Society has remained at a good level, and the outlook for the coming year continues to be good.

Counties and Secretaries	Members December 31, 1956		Members December 31, 1955	
	MAG	AMA	MAG	AMA
Banks	1	1	1	1
Blue Ridge				
T. J. Hicks, McCaysville .	11	9	11	10
Chattahoochee				
Fayette Sims, Lawrenceville	17	12	15	8
Cherokee-Pickens				
A. M. Hendrix, Canton .	14	10	15	10
Habersham				
J. J. Arrendale, Cornelia .	16	14	15	15
Hall				
Hamil Murray, Gainesville	40	32	41	30
Jackson-Barrow				
A. A. Rogers, Jr., Commerce	18	12	19	13
Rabun				
J. C. Dover, Clayton . .	2	2	3	3
Stephens				
C. L. Ayers, Toccoa . . .	15	11	13	11
	134	103	133	101

Reference Committee Recommendation—The report of the Ninth District Councilor was approved.

House of Delegates Action—Adopted the report of the Ninth District Councilor as recommended by the reference committee on motion duly made and seconded.

Public Health Committee

T. A. SAPPINGTON, M.D., Thomaston, Chairman

This committee has recommended a battery of suitable health screening tests which could be established as a periodic health appraisal for all personnel employed in the school system of Georgia. A copy of the recommendations to Council of the Medical Association of Georgia is listed below.

The chairman of this committee met with members of the State Health Department to amend the Physical Examination Act. This bill was drawn up and submitted to the State Legislature.

The State Public Health Department and the Medical Association of Georgia continue to work harmoniously.

Recommendations to Council from the committee appointed to determine a battery of suitable health screening tests which could be established as a periodic health appraisal for all personnel employed in the school system of Georgia is as follows:

First let it be definitely understood that these laboratory tests are to augment a complete physical examination by an M.D. and not to supplant a complete physical examination.

- 1. X-Ray chest.
- 2. Blood sugar — a urine sugar examination determination be done if not feasible to do blood sugar.
- 3. Hemoglobin.
- 4. Urinalysis for albumin.
- 5. Serology.
- 6. Height and weight determination.
- 7. Vision test — test similar to those done by the State Patrol and should be repeated yearly. Should require 20/30 minimum vision. These tests should include rough visual field determination, color vision, and Snellen chart.

8. Audiometer reading yearly — over 20 decibels loss in any tone between 250 to 8000 should suggest further check.

9. B/P (over 180/100 considered hypertension).

The above are tests that may be done by lay personnel or technicians. Let it be stated again — these are tests to be done to augment and not to supplant a complete physical examination by an M.D.

Reference Committee Recommendation—The report of the Public Health Committee was approved, with emphasis that these tests be done to augment and not supplant a complete physical examination by a private medical doctor.

House of Delegates Action—Adopted the Public Health Committee report as recommended by the reference committee on motion duly made and seconded.

Maternal and Infant Welfare Committee

CHARLES MCL. MULHERIN, M.D., Augusta, *Chairman*

I wish to report to you on the activities of the Maternal and Infant Welfare Committee during the past year. As you know, I have called your attention to the fact that for the past several years much planning has gone into the processing of the deaths by the cooperative action of the physicians concerned with each death, the State Public Health Departments and the executive office of MAG with the committee acting as overall guide. Questionnaires have been sent out, death certificates and autopsy reports reviewed, and in some instances personal interviews held. All of this has taken time in organizing, and it was not until late summer that the material had accumulated enough to consider holding a meeting. Unfortunately in September when I planned to hold a meeting, my youngest child suffered a fractured skull from a fall off of a horse, and I had to postpone any plans for a meeting. As a result only one meeting was held this year. This was held in October at the Dempsey Hotel and was a day long meeting, and I do think we accomplished a great deal. At least we have our organization for the processing of these deaths well formed. The wheels have started turning and future meetings should run smoothly.

The following is a report of the meeting:

Place: Dempsey Hotel, Macon, Georgia; Time: 9:30 a.m. to 6:00 p.m., with a luncheon intermission. Those present: Charles Mulherin, Chairman; Helen W. Bellhouse, Secretary; Eugene Griffin, Hugh Bickerstaff, Peter Hydrick, T. J. McPherson, James Bennett. Mr. Clint Terrill, Statistician, Georgia Dept. of Public Health, was an invited consultant. Dr. Simonton was unable to attend. Dr. Alexander has had to resign because of other MAG Committee responsibilities.

The first matter of business was a brief report on the present status of the perinatal mortality studies by Dr. McPherson — Tabulation has been completed on the 1954 figures, and they give promise of providing a great deal of valuable information to obstetricians, anaesthesiologists, and pathologists, as well as to pediatricians. As the discussion proceeded, several things became obvious: (1) the need for a control group of live births which survived; (2) the need for more complete reporting of birth weights; (3) the need for more complete recording; (4) the need for a sub-committee assigned the task of “looking behind” the tabulations for cause and effect; and (5) clarification of terms.

After discussion, it was recommended that two subcommittees be established, one using the present members, with the exception of the two pediatricians, to continue study of maternal deaths. The other subcommittee would be assigned to the perinatal studies, and would include, in addition to the present two pediatricians, two obstetricians, two general practitioners. The secretary would function to assist both subcommittees. The two subcommittees would meet jointly at least once a year and have planned meetings at other times. The chairman was asked to request that the president appoint the extra members required, probably on a staggered basis.

For purposes of the Maternal and Infant Welfare Committee “perinatal” is to include all fetal deaths after 20 weeks gestation (some figures were available on a weight basis) and neonatal deaths up to 28 days. This is stated as a matter of record, as there still is no nationally or internationally accepted definition. If later it seems desirable, the neonatal period can be broken down into smaller time intervals. At this point, the pediatricians retired with the statistician to review and plan for the perinatal studies. The rest of the committee turned its attention to the maternal deaths.

The committee accepted the AMA Maternal & Child Care Committee report, in principle (October 20, 1956 — AMA, Vol. 108 No. 8), and proceeded on this basis. A maternal death is “the death of any woman dying of any cause whatsoever while pregnant or within 90 days of the termination of the pregnancy, irrespective of the duration of the pregnancy at the time of termination or of the method by which it terminated”. This indicates the scope of the committee study and is not the same as the official state and national statistics which include only those deaths with international classification causes — 640 - 689. The latter depends on physician classification.

Seventy-five cases were reviewed on the basis of the anonymized reports from health departments and physicians. It was the impression of the committee that although responses to queries were increasing in numbers, but that there was still need for more complete information on which to arrive at conclusions and suggestions. Eight were set aside for requery.

Of the 63 cases closed, only 11 cases were considered non-preventable. Four cases were set aside, the deaths not occurring during pregnancy or within the 90 day interval following pregnancy, or being too indefinite. Interestingly enough, at least one death not coded as a maternal death according to the state and international coding system was assigned as a maternal death by the committee. The sequence of causes of death as described by the physician on the death certificate determines state and national coding.

Factors of preventability and responsibility were assigned in each maternal death. As the review proceeded, several things became obvious. Namely, (1) the need for more necropsies to establish cause precisely; (2) community and patient understanding of the value of and need for prenatal care and early hospitalization of abnormal obstetrics was lacking in a disturbingly high number of instances; (3) the problems of lack of available blood outnumbered the cases where unnecessary blood was given; and, (4) “anesthesia deaths” created concern.

As the meeting closed there was discussion as to how

to communicate with the great number of physicians requesting committee suggestions. A form letter is to be prepared, and the suggestions as developed by the committee will be incorporated in the body of the letter.

It was agreed that in the future all consultants named in the questionnaire replies be queried immediately so as to avert delay.

The secretary was instructed to continue developing a statement of procedure of processing both maternal death certificates and perinatal information.

Another meeting is planned, but no date set. At that time, reviews of more cases will be done and a re-review of cases considered at this meeting which have to be queried further will be included. Also, consideration will be given to the 1956 MAG resolution regarding the practicability of preparing graduate nurses to be of even more assistance in delivery services. This resolution had been referred to the committee, but time did not allow due consideration.

Reference Committee Recommendation—The Maternal and Infant Welfare Committee report was approved.

House of Delegates Action—Adopted the report of the Maternal and Infant Welfare Committee as recommended by the reference committee on motion duly made and seconded.

Medical Civil Preparedness Committee

E. M. DUNSTAN, M.D., Atlanta, *Chairman*

This year again work of the committee was intimately connected with that of the Medical Services Branch of the State Civil Defense Health Services Division, which has been in operation since February 19, 1951. Our committee is the main advisory group for this branch. Full minutes of the activities of this branch are in the official files.

Representatives of this committee attended the regular monthly school sessions and other meetings of this branch throughout the year and participated prominently in the following key activities.

1. Participated in the second year of instruction in the course on Catastrophic Injuries and Diseases instituted by the Emory University School of Dentistry as a regular course for senior dental students. This is now a regular 30-hour course in civil defense and represents the most complete course of its kind in the nation. Other dental schools are following this example and we will thus soon have dentists scattered widely in many communities who can instruct other dentists in this vital work as assistant surgeons for civil defense.

2. Participated in the coordination activities of the Implementation Committee for Region Three (Southeastern States) of the Federal Civil Defense Administration.

3. Worked with the Civil Defense Emergency Hospital pilot project of Emory University Hospital—DeKalb County.

4. Continued participating in the field testing of the Civil Defense 200-bed Emergency Hospital. Another demonstration was put on in Columbus, Georgia, August 13, 14, 1956, which was very successful.

The committee recommends that the 1957-58 Medical Civil Preparedness Committee be composed of a physician from each of the six key civil defense areas of the state, together with any other members-at-large which the president may wish to appoint.

Reference Committee Recommendation—The report of the Medical Civil Preparedness Committee was approved.

House of Delegates Action—Adopted the report of the Medical Civil Preparedness Committee as recommended by the reference committee on motion duly made and seconded.

Geriatrics Committee

EDGAR WOODY, JR., M.D., Atlanta, *Chairman*

Your Geriatrics Committee during the past year has initiated a program of lay education through the county medical societies whereby physician speakers are asked to address local civic groups. In this program it is hoped that the medical profession may be instrumental in acquainting our citizens with the overall problems of geriatrics as they apply to local communities. Also, in this program, stress is placed not only on the medical care problems of our senior citizens, but such problems as premature retirement and the importance of providing at the local level some outlet for at least part-time employment of some or utilization of acknowledged skills at least on a voluntary basis. With the rapidly increasing proportion of our citizens in the older age group, the importance of increasing the productive life of our population is of obvious importance. The response of the county medical societies to this program has been encouraging.

In January, 1957, the chairman attended a regional meeting on problems of the aged; it was sponsored by the United States Public Health Service and held in Tampa, Florida. This meeting proved to be both stimulating and informative, and many useful ideas were gleaned for setting up a useful and active geriatrics program in Georgia.

Reference Committee Recommendation—The Geriatrics Committee report was approved.

House of Delegates Action—Adopted the Geriatrics Committee report as recommended by the reference committee on motion duly made and seconded.

Headquarters Office Report

MR. MILTON D. KRUEGER, Atlanta, *Executive Secretary*

MR. JOHN F. KISER, Atlanta, *Asst. Executive Secretary*

Headquarters Office Staff—Headquarters Office personnel greatly increased their amount of activity in their respective capacities during 1956-57. The Office staff, now experienced in MAG operations and procedures, stabilized progress made during previous years and established efficient office routines. Staff assignment and responsibility include: Mr. Krueger, Executive Secretary, Council, office management, committees and meetings; Mr. Kiser, Asst. Executive Secretary, field travel, public relations, committees and meetings; Miss Frances Porcher, *Journal* Managing Editor, management of *Journal of the Medical Association of Georgia*; Miss Thelma Franklin, bookkeeping, membership records; Mrs. Myrtice Mulligan, office secretary; and Mrs. Sue Shore, general secretary and receptionist.

With the advent of the Dependents' Medical Care Act, Public Law 569 (84th Congress) better known as "Medicare," the Headquarters Office staff was enlarged to administer this program. Mr. Dougald M. Avera was employed to install and maintain an adequate processing and payment procedure for Medicare claims. Mrs. Jean Buice works with Mr. Avera in the processing and recording of claim forms. It is likely that an additional assistant will be hired in the near future if the volume of Medicare claims continues at the present high rate.

Headquarters Office Activity—In serving the House of Delegates, Council, the Association committees and component county medical societies, the requests for assistance have on occasions exceeded the facilities of the Headquarters Office during 1956-57. It is apparent that without moderate expansion in both personnel and office space, the ever increasing volume of work cannot be carried on adequately. While routine activities are handled efficiently in the present status, it has become necessary to delay and curtail certain new projects in order to meet the most pressing commitments. Reports of Council, committees, and MAG officers reflect this surge of pending and new activity and planning, and provision must be made if the Headquarters Office work load is to be appreciably increased as present trends indicate. For example, the following activities have had to be conducted on a limited scale only: Salk Polio Vaccine program; VA Committee activity; Hospital Committee activity; Highway Auto Safety Program; liaison with specialty societies; Public Relations Committee activity; county society visitation program, etc.

The following projects were proposed but could not be carried out: membership indoctrination booklet, county society model constitution and by-laws, county society officers conference, committee chairmen orientation dinner, medical education week activity, etc.

Recommendations—That the House of Delegates instruct the Executive Committee of Council to ascertain the extent of personnel and office space increase and expansion necessary to adequately service the Association and further that the House of Delegates authorize the Council to provide for this expansion if Council deems it in the best interests of the Association.

In closing, we would like to express our sincere appreciation for the fine cooperation of the many officers, councilors and committeemen with whom we worked during the past year.

Reference Committee Recommendation—The Headquarters Office report was approved with the recommendation that Council report to the House of Delegates for their approval any contemplated major building expansion.

House of Delegates Action—Adopted the Headquarters Office report as recommended and altered by the reference committee on motion duly made and seconded.

Secretary

DAVID HENRY POER, M.D., Atlanta

Without regard to contents, some historical interest may be found in the final report of your secretary, who has literally "organized himself out of a job." Six years ago the voting members of the Association gave approval to a proposed capital plan of reorganization which centered mostly around the employment of an executive secretary and a staff of administrative assistants and the transfer to them of the duties formerly performed by the secretary-treasurer on a part-time salaried basis. Three years ago an even larger percentage of the members again gave their approval, even though a few openly objected to "progress" and the increased expenditure of funds to provide additional services. Now at the end of five and a half years, I can report to you that the reorganization of the administrative offices of the Association is "il fait accompli", and the concentration of authority and responsibility in one elected official no longer exists.

Not fully appreciated by many including myself was the extent to which the secretary-treasurer had respon-

sibilities ordinarily assumed by a governing board of directors such as Council. It is true that this body did exist and function on call at irregular intervals, but no records of activities were kept or published, so little is known of their true function. Therefore, it has become necessary during the past five years for Council to "find itself" and to take over its full responsibility of running the Association between meetings of the House of Delegates. That this has been done in a decisive manner has been demonstrated on several occasions in recent months when members of Council were not in agreement with recommendations of the secretary-treasurer and have followed their own decisions.

Another situation that has entered the picture has been the tremendous increase in both the volume and importance of medical organizational work. This has made the need and value of both the well-staffed executive offices and the Council capable of making decisions for the Association all the more apparent. All indications point to the fact that these problems will continue to increase along with the complexities of medical practice in the future.

In concluding these details it should be said that the administrative responsibilities of the House of Delegates have been perfected with an efficient organization which has benefited greatly by the election of delegates for a three-year term of office. These terms are so staggered that not more than one-third of the delegates are elected each year. This means that members with considerable experience are always on hand to handle such matters as present themselves. Also, the control of the House by a speaker and a vice-speaker has greatly improved that organization.

The one spoke in this wagon wheel of administration which has not reached its peak in efficiency is the Executive Committee of Council. Regular monthly meetings are scheduled but conflicts interfere, and two members (the past president and the president-elect) have been hesitant to do more than give approval to the policies of the administration. This has resulted in the other four members (president, chairman of council, chairman of finance committee, and secretary) making medical decisions on a day-by-day basis as individuals rather than as a policy group. It is my own impression that this makes for inefficiency and a possible lack of harmony between the executive staff and the medical officers in control of policy. I believe that the announcement of all decisions on matters controlled by the Executive Committee should be made by one medical administrative officer.


As an ex-officio member of all committees of the Association, I would like to make the following additions to other reports for action by the proper reference committees:

(1) *Officers*—(a) Following the custom of other organizations of similar type, it is recommended that the President's Address be given at the time of his inauguration. This has been suggested repeatedly for several years but no action has been taken.

(b) *Vice-Presidents*: Under the present system it is doubted that vice-presidents can become very effective members of Council with terms of only one year. It is therefore recommended that their term of office be extended to three years. Also, the practice of electing both vice-presidents from the same county society has many objections (all four officers at present are mem-

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1. Boger, W. P.; Strickland, C. S.; and Gylfe, J. M.: Antibiot. Med. & Clin. Ther. 3:378 (Nov.) 1956.

*Reg. U.S. Pat. Off.

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bers of the same county society), and it is therefore recommended that no two vice-presidents be elected from the same county medical society.

(2) *District Societies*—It is a matter of record that the larger county societies in the state take little or no part in the activities of the district societies, and in truth, with a marked improvement in transportation and good roads, the need for district societies has decreased greatly. Since councilors are elected by the district societies, this means that the large societies have little or no direct representation in that body except for the fact that most of the officers are from the large societies. Since these societies make up over half the membership of the Association, it is recommended that a special committee be set up to study this situation and make recommendations to the House of Delegates at its next meeting.

(3) *Membership*—Membership figures for the year ending December 31 are as follows:

Active	2,342
Active Dues Exempt	311
Service	46
Associate	10
Honorary	1
Total	2,710

(4) *Committees*—The total inactivity or only partial inactivity of many important committees within the structure of this organization has been the cause for worry and comment by practically all of our past-presidents within my memory. Many state societies have made radical changes in the organization of their committees, and it is recommended that this be done in this state, and that a report be made to Council within six months.

(5) *Awards*—Since the Medical Association of Georgia has no method at the present time for the proper recognition of the distinguished services to the Association by any of its members, it is recommended that the Association recognize such outstanding service and ability by the presentation of an award at the time of the annual session following the approval by at least three-fourths of the members of Council. This shall be known as the Medical Association of Georgia Award for Distinguished Service. (Note: The Hardman Cup Award can be made only for "attaining any outstanding problem in public health, or making a discovery in medicine or surgery.")

(6) *Legislation*—The work of this committee becomes more important with each meeting of the General Assembly. More thought and study will have to be made by policy making groups well in advance of each session so that the Association's position on controversial matters can be given with proper authorization. This is particularly true in regard to the practice of cultists in this state, and it is recommended that the special committee set up to study this problem report its findings to Council within six months if at all possible.

(7) *Medical Boards and Committees Controlled by the Administration of the State of Georgia*—The governor of the State of Georgia is under no obligation whatsoever to follow the recommendations of the Medical Association of Georgia to fill vacancies on any board except the State Board of Health. This does not follow custom or tradition which leaves the control of professional matters to the responsible medical organi-

zation in that state. It is felt that our own members with political ambitions can be very helpful to the Association in this matter by having the governor at least request recommendations before any vacancy is filled. It is not felt that any specific recommendations would be helpful beyond this request.

(8) *Tenure of Office*—There are many advantages to having the "good" committee chairman reappointed as long as he will continue to function efficiently. It is certainly true that everyone should be given plenty of time to get a program properly organized and the committee functioning efficiently. However, there are many disadvantages to having the man who thinks that no one else can do the work quite as well as he continue on the job forever. This has been the cause of great dissatisfaction and disharmony in many similar state organizations. Certainly, somewhere between the two extremes should be found the correct answer, and this will always have to come from within the individual himself.

(9) *The Future*—I sincerely believe that the management of the affairs of the Medical Association of Georgia are in the most capable hands of its entire history, and it is my hope that no changes will be made in the near future. Our methods are certainly more democratic than ever before, and the increasing number of young physicians will insure virile and potent activity.

In bringing this era in the history of the Medical Association of Georgia to an end, I want to express again my sincere thanks and appreciation to all of those who have made our success possible. In particular, I want to express my appreciation to a very loyal and efficient executive staff headed by Mr. Milton D. Krueger and including each and every member of his staff. To Dr. Woody and the entire staff of the *Journal* I hold debts of gratitude for kindly understanding and the production of a wonderful journal. Our president, Hal Davison, has been both friend and advisor and has helped smooth out many rough spots. He has worked hard for the Association at the expense of his own health and time, and it is now my opportunity to advise him to "take care of himself." The list of friends in Council, in the House of Delegates, and in the Association is endless because even those who have disagreed with me politically have given me their full strength, support, and cooperation, and I come to the end of this term of office with an humble word of thanks to everyone.

Reference Committee Recommendation—The report of the Secretary was read and approved with the following exceptions: (1) It was felt that the President's Address should be given just prior to the nomination of new officers. (2) It was felt that the vice-presidents should not be elected for a term of three years, but the committee felt that no two vice-presidents should be elected from the same county society.

House of Delegates Action—Adopted the report of the Secretary as recommended and altered by the reference committee on motion duly made and seconded.

Treasurer

DAVID HENRY POER, M.D., Atlanta

As noted above in the report of the secretary, the reorganization of the administration of the Association has brought about the appointment and operation of a very efficient Finance Committee of Council, and all financial matters are handled by that committee which reports directly to Council. The report of this

committee will be found in the *Delegates Handbook*. The budget system has been in operation for several years and has inestimable value for day by day control of the monies of the Association. The steady increase in activities has added to our requirements for personnel, equipment, and space, and these are reflected in the fact that this year the Association is operating on a deficit budget. Fortunately, some money had been put in savings accounts during the past several

years, and this will be available before we actually go into fixed reserves. Perhaps the members of the Association will want to make other changes before that time comes.

To Miss Thelma Franklin, our efficient bookkeeper who does not know what the term "time-clock" means, I owe a deep debt of thanks and appreciation for her assistance in watching over the financial affairs of the Association.

STATEMENT OF ASSETS AND LIABILITIES — BY FUNDS
The Medical Association of Georgia
Year ended December 31, 1956

ASSETS	General Fund	Benevolent and Building Funds	Abner W. Calhoun Lectureship Fund	Combined
Cash on deposit and on hand	\$23,106.64	\$ -0-	\$ 406.43	\$ 23,513.07
Securities owned:				
At cost	-0-	50,000.00	6,101.85	56,101.85
At redemption prices	-0-	16,888.00	-0-	16,888.00
Accounts receivable	10,299.52	-0-	-0-	10,299.52
Travel deposit	425.00	-0-	-0-	425.00
Office furniture and equipment—Note A . .	\$ 8,695.30	\$ -0-	\$ -0-	\$ 8,695.30
Less* allowance for depreciation	2,533.16*	-0-	-0-	2,533.16*
	<u>\$ 6,162.14</u>	<u>\$ -0-</u>	<u>\$ -0-</u>	<u>\$ 6,162.14</u>
Office supplies inventory	114.61	-0-	-0-	114.61
Prepaid 1957 annual meeting expense . . .	1,275.00	-0-	-0-	1,275.00
TOTAL ASSETS	<u>\$41,382.91</u>	<u>\$66,888.00</u>	<u>\$ 6,508.28</u>	<u>\$114,779.19</u>
LIABILITIES				
Accounts payable	\$ 5,422.94	\$ -0-	\$ -0-	\$ 5,422.94
Deferred income:				
Exhibitors' fees 1957				
Annual meeting:				
Collected	\$ 4,900.00	\$ -0-	\$ -0-	\$ 4,900.00
Due from exhibitors	2,800.00	-0-	-0-	2,800.00
	<u>\$ 7,700.00</u>	<u>\$ -0-</u>	<u>\$ -0-</u>	<u>\$ 7,700.00</u>
TOTAL LIABILITIES	<u>\$13,122.94</u>	<u>\$ -0-</u>	<u>\$ -0-</u>	<u>\$ 13,122.94</u>
EXCESS OF ASSETS OVER LIABILITIES . . .	<u>\$28,259.97</u>	<u>\$66,888.00</u>	<u>\$ 6,508.28</u>	<u>\$101,656.25</u>

NOTE A—Office furniture and equipment is stated on the basis of cost and does not include items purchased prior to April 1, 1949.

STATEMENT OF INCOME AND EXPENSE — BY FUNDS
The Medical Association of Georgia
December 31, 1956

INCOME	General Fund	Benevolent and Building Funds	Abner W. Calhoun Lectureship Fund	Combined
Membership dues:				
Year 1956	\$57,512.50	\$ -0-	\$ -0-	\$57,512.50
Prior years	746.25	-0-	-0-	746.25
Less* allocated to subscriptions to				
The Journal	11,487.50*	-0-	-0-	11,487.50*
	<u>\$46,771.25</u>	<u>\$ -0-</u>	<u>\$ -0-</u>	<u>\$46,771.25</u>
Net income from The Journal	3,916.48	-0-	-0-	3,916.48
Interest on U. S. Savings Bonds:				
Received—Note A	1,250.00	-0-	-0-	1,250.00
Increase in redemption values	-0-	408.00	-0-	408.00
Interest received on savings share accounts .	712.50	-0-	-0-	712.50
Dividends on stocks owned	-0-	-0-	263.92	263.92
TOTAL INCOME	<u>\$52,650.23</u>	<u>\$408.00</u>	<u>\$263.92</u>	<u>\$53,322.15</u>

EXPENSE	General Fund	Benevolent and Building Funds	Abner W. Calhoun Lectureship Fund	Combined
Salaries (Note B):				
Secretary and treasurer	\$ 3,000.00	\$ -0-	\$ -0-	\$ 3,000.00
Executive secretary	7,033.33	-0-	-0-	7,033.33
Asst. Executive secretary	5,275.00	-0-	-0-	5,275.00
Clerical	7,462.50	-0-	-0-	7,462.50
Less* allocated to The Journal	3,000.00*	-0-	-0-	3,000.00*
	<u>\$19,770.83</u>	<u>\$ -0-</u>	<u>\$ -0-</u>	<u>\$19,770.83</u>
Trustee's fee	-0-	-0-	13.20	13.20
Expenses of 1956 meeting, less fees from exhibitors of \$10,650.00	1,373.78	-0-	-0-	1,373.78
EXPENSE				
Administrative and other expenses	\$30,470.11	\$ -0-	\$ -0-	\$30,470.11
TOTAL EXPENSE	<u>\$51,614.72</u>	<u>\$ -0-</u>	<u>\$ 13.20</u>	<u>\$51,627.92</u>
	\$ 1,035.51	\$408.00	\$250.72	\$ 1,694.23
OTHER INCOME				
Received from AMA for services, postage, etc.	544.37	-0-	-0-	544.37
NET INCOME	<u>\$ 1,579.88</u>	<u>\$408.00</u>	<u>\$250.72</u>	<u>\$ 2,238.60</u>

NOTE A—On May 10, 1953, The Council authorized interest received on U. S. Savings bonds held in the Benevolent and Building Funds to be recorded in the general fund.

NOTE B—Clerical salary in the amount of \$2,475.00 has been charged directly to expenses of 1956 meeting in the above statement.

Reference Committee Recommendations—The report of the Treasurer was approved.

House of Delegates Action—Adopted the report of the Treasurer as recommended by the reference committee on motion duly made and seconded.

ADDENDUM NO. 7—MEDICAL CIVIL PREPAREDNESS COMMITTEE

EDGAR M. DUNSTAN, M.D.

1. Approve federal plans to provide shelters for protection of civilians against nuclear and thermo-nuclear attack as the best method of shielding, within limits of financial resources of the country.
2. Upgrade the office of Administrator of the Federal Civil Defense authority to cabinet status.
3. Approve plans of FCDA to conduct a study and research project at expense of the government.
4. Urge all counties to send representatives to National Medical Civil Defense Conference to be held before AMA meeting in New York City, June 1st.

Reference Committee Recommendation—Addendum No. 7, to the Medical Civil Preparedness Committee report, was approved.

House of Delegates Action—Adopted Addendum No. 7, to Medical Civil Preparedness Committee report, as recommended by the reference committee on motion duly made and seconded.

Resolution No. 5

Hospitalization of Patients with Alcoholism

SCOTT L. TARPLEE, M.D., Atlanta

WHEREAS, the illness of alcoholism in the State of Georgia is of increasing concern to the people and medical profession and has become a serious public health problem, and

WHEREAS, the need for prevention, education, and early and adequate treatment is of importance to the welfare of each county for control of this serious and often fatal illness, and

WHEREAS, alcoholism is now recognized as a medical problem, the alcoholic patient is a sick person whose

illness can be treated, and it is often a medical emergency requiring urgent admission to a general hospital. Because of the diagnosis of alcoholism these patients are refused admission to some general hospitals, and

WHEREAS, these are problems of the alcoholic patient, the medical profession, and hospitals throughout the country, as evidenced by a "Resolution on Hospitalization for Patients with Alcoholism" of the Committee on Alcoholism of the AMA Council on Mental Health which was recently presented to and approved by the House of Delegates of the American Medical Association,

THEREFORE BE IT RESOLVED that the House of Delegates of the Medical Association of Georgia endorse the principle and purpose of this AMA "Resolution on Hospitalization for Patients with Alcoholism", and ask that delegates from the various counties throughout Georgia urge their respective hospital administrators and staffs to look upon alcoholism as a medical problem, to admit cooperative alcoholic patients for treatment, and to help these patients and their families understand the need for early and adequate treatment as would be given patients with any other illness;

BE IT FURTHER RESOLVED that each member of the Medical Association of Georgia be requested to lend his effort by supporting education and research to further the control of alcoholism in the State of Georgia.

Reference Committee Recommendation—Resolution No. 5, on Hospitalization of Patients with Alcoholism, was approved.

House of Delegates Action—Adopted Resolution No. 5, on Hospitalization of Patients with Alcoholism, as recommended by the reference committee on motion duly made and seconded.

Resolution No. 7

Nursing Shortage

THOMAS J. ANDERSON, JR., M.D., Atlanta

WHEREAS, the continuing shortage of nurses seriously threatens adequate patient care in our hospitals, and

WHEREAS, national accrediting and examining au-

thorities are advocating requirements for hospital schools of nursing which are unrealistic in terms of their purpose or the positions for which their graduates are trained, and thereby affect the supply of nurses, and

WHEREAS, the training requirements advocated for faculty positions in hospital schools of nursing are unrealistic in that the supply of eligible applicants is inadequate to staff these schools at the present time, and

WHEREAS, it is the opinion of the medical profession of Georgia that the program of hospital schools of nursing should stress the development of nursing skills through learning experiences at the bedside of the patient, and, further that the requirements being advocated will tend to withdraw the student from such experiences, thereby limiting the amount and quality of available patient care;

THEREFORE BE IT RESOLVED that the Medical Association of Georgia request the Governor of the State of Georgia to appoint a commission on nursing, composed of three practicing physicians, three nursing service administrators, three nursing educators, three hospital administrators, and one leader in general education, and one economist, the purpose of the commission being to determine the effect of these matters upon the present critical shortage of nurses and upon the adequacy of patient care in Georgia, through a program of studies and conferences resulting in a series of reports to the Governor, and to the people of Georgia containing the recommendations of the commission.

BE IT FURTHER RESOLVED that the Medical Association of Georgia ask the Governor of the State of Georgia to petition the President of the United States to call a national conference with representatives as outlined for the Georgia commission from each state to consider the nursing shortage and its causes.

BE IT FURTHER RESOLVED that the Medical Association of Georgia Delegates to the AMA be instructed to present a similar resolution to the House of Delegates of that organization.

Reference Committee Recommendation—Resolution No. 7, on Nursing Shortage, was approved.

House of Delegates Action—Adopted Resolution No. 7, on Nursing Shortage, as recommended by the reference committee on motion duly made and seconded.

Resolution No. 10

Fund for Students to SAMA Convention

R. C. MCGAHEE, M.D., Augusta

WHEREAS, the Student American Medical Association was organized by the American Medical Association, and

WHEREAS, this student organization is concerned not only with problems at the undergraduate level but at the same time helps prepare them to meet the problems of practice and therefore become better physicians, and

WHEREAS, this organization has its own national House of Delegates meeting annually where policies are made and interpreted, and

WHEREAS, there is granted by our medical colleges funds sufficient for only one delegate, whereas two or more are needed to participate in activities which are taking place concurrently,

THEREFORE, BE IT RESOLVED that the Medical Association of Georgia establish a fund sufficient to send one student from each of our two medical schools,

this amount not to exceed \$150.00 for each representative.

Reference Committee Recommendation—Resolution No. 10, on Funds for Students to SAMA Convention, was approved, if funds are available and if Council feels that enough interest is being maintained in the medical school to warrant this expenditure.

House of Delegates Action—Adopted Resolution No. 10, on Funds for Students to SAMA Convention, as recommended and altered by reference committee on motion duly made and seconded.

On motion duly made and seconded, it was moved that the report be adopted as a whole with certain changes noted. This motion was then approved.

Report of Reference Committee No. 4

E. C. McMillan, Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 4 met at 2:00 p.m., April 29, in Room 700, Hotel DeSoto, Savannah. Members present were: E. C. McMillan, Macon, Chairman; Linton H. Bishop, Jr., Atlanta; Charles T. Cowart, LaGrange, Secretary; W. L. Pomeroy, Waycross; Paul Bradley, Dalton; James W. Yeomans, Jesup; R. J. Moye, Swainsboro; William P. Harbin, Jr., Rome.

First Vice-President

CARL C. AVEN, M.D., Atlanta

The most important function and duty of the first vice-president is that it provides membership on the Council. I have attended all but one meeting this year. My observation is that few members realize the time, travel, and financial loss to those serving on Council. Reports of the Council activities will be given by various officers.

One further observation is that as the demand for services increases either deficit financing will be necessary or an increase in dues must be made at once. It has been a pleasure to offer my small contribution in trying to arrive at reasonable decisions on some very perplexing problems that have arisen this year.

Reference Committee Recommendation—Reference Committee No. 4 recommends acceptance for information.

House of Delegates Action—Accepted the First Vice-President's report as recommended by the reference committee on motion duly made and seconded.

Second Vice-President

BERNARD P. WOLFF, M.D., Atlanta

A few years ago a movement was started by the vice-presidents to place more than an honorary title on their office. Since then, these once purely nominal officers have been given more and more of a part in the management of the Medical Association of Georgia. Not only are these men voting members of Council, but they are also members of hard working and active committees.

My experiences as second vice-president have been

engaging to say the least. After attending a few meetings, it became apparent that much business was at hand, and the Council was eager to have at it.

Many sticky problems arose at each meeting. The Medicare program, the Talmadge Hospital, and the ever present questions of corporate medical practice were fair examples of the agenda of Council meetings.

As a newcomer to these meetings, I was variously impressed; the complexity of problems was appalling but mainly I was impressed with the Council itself. Drs. Schaefer and Davison were outstanding, and Dr. Chambers the best presiding officer I've ever seen. Dr. Poer and the Messrs. Krueger and Kiser were able to unerringly pinpoint each knot in the problems. But it was the main body that came up with the final answer. The spice of personal politics occasionally added zest to the meetings.

As chairman of the Workmen's Compensation Committee, I was led into researches on the choice and selection of a physician in compensation cases. The committee decided in favor of free choice of a physician by the employee and will so recommend to Council.

As a member of the Legal Committee, I was instrumental in the selection of Mr. Shackelford, who has done such an outstanding job as special counsel to MAG.

Finally, I should like to recommend that the candidates for all offices in MAG be chosen from the roster of present or recently past members of Council. This would insure a man with the experience and leadership which in these hazardous and touchy times we so greatly need. Also, I would like to propose that every officer continue as a member at large of Council for at least one year after his term has expired.

Reference Committee Recommendation—Reference Committee No. 4 recommends to the House of Delegates that it accept paragraphs one, two, three, four, five, and six as information. The committee opposes the recommendation in paragraph seven, namely, that the candidates for all offices in the Medical Association of Georgia be chosen from the roster of present or recently past members of Council.

House of Delegates Action—Accepted the report of the Second Vice-President as recommended by reference committee concerning paragraphs one, two, three, four, five, and six as information. Approved the reference committee action concerning paragraph seven. This action was then adopted on motion duly made and seconded.

Report of Council

GEORGE R. DILLINGER, M.D., Thomasville

REMARKS

The business and varied activities of your Association are growing by leaps and bounds. From the moment of the Council organizational meeting held in Atlanta on May 16, 1956, at the close of the last Annual Session, the Council and its Executive Committee have dealt with numerous and varied problems. We can only hope to present to you in this report, the highlights of our activities.

At the May 16, 1956, organizational meeting, J. W. Chambers, LaGrange, was elected chairman and George R. Dillinger, Thomasville, was elected vice-chairman. The Finance Committee was appointed with George R. Dillinger, Thomasville, chairman; J. G. McDaniel, Atlanta, and D. Lloyd Wood, Dalton, as the other members.

At this time, I can only pay tribute to the members of Council for their diligence and conscientious attend-

ance at the meetings of both the Council and the Executive Committee. I wish that every member of your MAG House of Delegates could sit in on one of our Council meetings so that you might understand the seriousness and the attention to business given by members of the Council to the multitudinous problems confronting the medical profession. I further wish to bring to your attention the unceasing devotion and care to every detail given this work by Council Chairman, Dr. Chambers, LaGrange. During the last two years under his chairmanship, your Council has functioned as never before. He has been on the job every minute and has dealt with every problem in an impartial and statesmanlike manner. The members of the Council feel that we all owe him a debt we can never repay and that he is worthy of any honor that the Association may bestow upon him.

I must, at this time, also pay tribute to your President, Hal M. Davison, for his attention to detail, his attendance at Council and Executive Committee meetings, and his frequent travel over the State of Georgia in the interest of your Association. He has done a monumental task during his term of office as president and has contributed greatly to the leading position in which your Association now finds itself. I must also commend the secretary-treasurer for his diligence in the excellent work that he is doing and has done for our Association during the past several years. We must pay tribute to Edgar Woody, Jr., Editor of the *Journal*, for the excellence of that publication, and we must also pay tribute to the excellent and forthright manner in which our Headquarters Staff is functioning. The executive secretaries and the others of the office personnel must be commended for their loyalty and devotion to duty in our interests. I could spend a great deal of time in discussing and approving the activities of the many individuals concerned with the operation of our Association, but time and space will not permit me to do so.

We can already see many beneficial effects from the adoption of the revised Constitution and By-Laws as adopted at the 1956 Annual Session. To date, Council has considered only two minor problems. One being that there was no quorum defined for the Executive Committee, and the other being some consideration as to changes needed on committees of the Association, together with the duties of the vice-presidents.

Reference Committee Recommendation—Reference Committee No. 4 recommends acceptance of the section titled "Remarks" as information.

House of Delegates Action—Accepted the section of the Council report entitled "Remarks" as recommended by the reference committee on motion duly made and seconded.

FINANCE

Your Finance Committee has been diligent and has attempted to keep the expenditures of the Association within bounds. I would like to call your attention to the report of the treasurer and to the report of the Finance Committee as approved by Council and included herein as follows:

	1956 Budget	Income and Disbursements Dec. 6, 1956	1957 Tentative Budget
INCOME			
Income from Dues . .	\$55,500.00	\$57,925.00	\$57,000.00
Journal Advertising . .	23,000.00	25,325.69	25,000.00
Fees Exhibitors A. S. .	9,000.00	10,650.00	8,750.00
Int. & AMA Service . .	2,000.00	2,156.87	2,200.00
		<hr/>	<hr/>
		\$89,500.00	\$96,057.56
			\$92,950.00

	1956 Budget	Income and Disbursements Dec. 6, 1956	1957 Tentative Budget
DISBURSEMENTS			
1. <i>Salaries</i>	\$26,600.00	\$26,650.00	\$26,675.00
2. <i>Fixed Allotments</i>			
Pension Payments . .	\$ 1,200.00	\$ 600.00	\$ 1,200.00
Honorarium—Pres. . .	1,000.00	1,000.00	1,000.00
Attorney Retainer . .	1,020.00	1,200.00	1,200.00
Annual Audit	400.00	500.00	500.00
Cont. F.C.M.S. . . .	1,500.00	1,500.00	1,500.00
Ins. & Bonds Pers. . .	100.00	20.40	1,000.00
Woman's Auxiliary . .	1,300.00	1,300.00	1,300.00
Better Health Council	1,200.00	1,200.00	1,200.00
	\$ 7,900.00	\$ 7,320.40	\$ 8,900.00
3. <i>Journal Publication</i>			
Salaries \$	—	—	\$ 4,800.00
Engraving & Cuts . . .	800.00	826.01	900.00
Editorial Asst.	150.00	150.00	150.00
Stationery	650.00	644.77	300.00
Postage	500.00	495.00	500.00
Clipping Service . . .	250.00	205.00	250.00
Add. & Supplies . . .	200.00	178.86	200.00
Copyright	50.00	48.00	50.00
Printing	22,000.00	24,992.23	26,000.00
Sales Tax	—	—	780.00
Sundry	—	—	50.00
	\$24,600.00	\$27,555.87	\$33,980.00
4. <i>Headquarters Expense</i>			
Travel \$	5,000.00	\$ 6,263.22	\$ 4,000.00
Travel AMA			
Del. & Sec.	—	—	2,000.00
Meetings	500.00	496.80	500.00
Stat. Print. & Sup. . .	1,200.00	1,537.08	1,500.00
Postage	1,000.00	1,336.67	1,500.00
Tel. & Tel.	2,200.00	2,741.69	2,500.00
Depreciation	500.00	—	500.00
Office Sup. & Exp. . .	600.00	479.11	500.00
Dues & Sub.	200.00	196.01	200.00
Janitor Service . . .	300.00	300.00	300.00
Payroll & Unem-			
ployment Tax . . .	600.00	517.00	1,400.00
Sundry	600.00	409.19	500.00
	\$12,700.00	\$14,276.77	\$15,400.00
5. <i>Annual Session</i> . . .		\$ 267.09 (1957)	
	\$ 9,000.00	11,557.94	\$10,000.00
6. <i>Committee Expense</i>			
1. Rural Health . . . \$	200.00	\$ 185.27	\$ 350.00
2. Medical Defense . .	200.00	1,483.02	500.00
3. Legislation	1,000.00	399.92	1,400.00
4. Maternal Welfare . .	200.00	—	200.00
5. Industrial Health . .	100.00	100.00	100.00
6. Public Relations . .	1,000.00	615.14	1,000.00
7. Ins. & Economics . .	300.00	400.97	300.00
8. Awards	150.00	122.32	100.00
9. AMEF	—	—	100.00
10. Veterans Affairs . .	150.00	—	150.00
11. Hosp. Relations . .	150.00	103.73	150.00
12. Hist. & Vital Sta. . .	300.00	—	—
13. Med. Civil Prep. . .	50.00	9.79	50.00
14. Blood Banks	50.00	—	50.00
15. Mental Health . . .	250.00	12.00	275.00
16. Crawford W. Long . .	—	44.57	100.00
17. Medical Education . .	—	—	100.00
	\$ 4,200.00	\$ 3,576.73	\$ 4,925.00
Total Disbursements	\$85,000.00	\$91,204.80	\$99,880.00
Contingent Fund	4,500.00	4,941.90	6,930.00
			def.
Georgia Plan	—	399.43	—
Employee's Hosp.	—	442.10	—
Liability Insurance . . .	—	311.77	—
South. Journal Conf. . . .	—	391.16	—
Equip. Diebold Files, Dictaphone	—	1,403.10	—

Balance Contingent Fund	\$ 1,905.11
Bank Balance (Dec. Salaries Deducted)	\$ 7,347.11

During the calendar year of 1956 we want you to note that up to January 1, 1957, the Medical Association of Georgia was able to stay within its income with a surplus of approximately \$1,200 at the end of the year. However, due to numerous factors, the Council approved budget for 1957 is a deficit budget although we had hoped that some increase in income would more than offset this anticipated deficit. However, certain unanticipated expenditures have arisen such as fees for legal counsel, wearing out of the Headquarters mimeograph machine, anticipated loss on this Annual Session, over-expenditure of funds by the Legislative Committee, etc., make it extremely unlikely that the Association can stay in the black this year.

Reference Committee Recommendation—Reference Committee No. 4 accepts the financial report for information noting that the Association is now in deficit spending, and recommends that the dues be increased by the sum of \$15.00 per year. The committee recommends that in the future whenever a raise in dues is necessary that the Council make a definite specific recommendation to the House of Delegates.

House of Delegates Action—Accepted the section titled "Finance" of the Council report as recommended by the reference committee on motion duly made and seconded, and approved by unanimous voice vote the recommendation of Reference Committee No. 4 that the dues be increased by the sum of \$15.00 per year.

PERSONNEL POLICIES

The Finance Committee, with the approval of Council, has set up definite policies for the Headquarters Office personnel and employees of the Association as follows:

(1) That each Association employee be covered at the Association's expense by Blue Shield-Blue Cross Insurance (already in force per December 17, 1955, Executive Committee of Council meeting minutes.)

(2) Sick Leave—That each employee be retained on the payroll for the following prescribed period in the event of actual sickness or accident and that any absence due to actual sickness or accident extending beyond the above limitation be considered absence without pay at the discretion of the Executive Committee of Council.

During 1st year of employment . . .	1 week
During 2nd year of employment . . .	2 weeks
During 5th year of employment . . .	3 weeks

(3) Vacations—That each employee be allowed the following annual vacation with pay:

During 1st year of employment (after 6 months of service)	1 week
During 2nd year of employment . . .	2 weeks
During 5th year of employment . . .	3 weeks

(4) Christmas Bonus—That each employee receive an annual bonus at Christmastime if that employee is on the Association payroll as of December 25, and at no time during the year should an employee receive additional bonus, and the amount of this Christmas bonus to be set as follows:

After completion of 1st year of employment	1/4 months pay
After completion of 2nd year of employment	1/2 months pay
After completion of 5th year of employment	3/4 months pay

After completion of 10th year
of employment 1 months pay

On motion (Dillinger-McDaniel) it was moved that as of the 1956 Annual Session, and effective after that date, the salary of the secretary of the Association be \$1,200 annually, and that the salary for the treasurer be \$500.00 annually. It was left to the discretion of the Council and the physicians elected and appointed to these positions as to whether this should be listed as salary or honorarium.

Therefore, gentlemen of the House of Delegates, for the year 1957 your Association is operating on a deficit budget and is now making appropriations from the Association reserve fund.

Reference Committee Recommendation—The committee recommends approval of the employees' benefits, namely Blue Cross-Blue Shield insurance premium plan, sick leave as scheduled, vacations as scheduled, and Christmas bonuses as scheduled, and further recommends approval of the annual salaries of the Secretary and the Treasurer.

House of Delegates Action—Adopted the section of the Council report titled "Personnel Policies," as recommended by the reference committee on motion duly made and seconded.

MEDICARE

One of the big problems that your Association has had to consider during the last year is that of the Military Dependents' Medical Care Act, Public Law 569, 84th Congress, better known as "Medicare". Your secretary, David Henry Poer, attended a Medicare meeting sponsored by the American Medical Association on July 28, 1956. A regional Medicare meeting was held in Atlanta on August 19, 1956, which included nine Southeastern states. The Medical Association of Georgia sponsored this meeting, and Medicare problems were discussed thoroughly. The Executive Committee of Council meeting on September 16, 1956, the Council meeting of September 15-16 dealt with the organization of the Georgia Medicare program.

Chairman of Council, Dr. Chambers, reported that he had appointed a committee to study and recommend the usual fees for medical and surgical procedures requested by the Department of Defense. This was done in consultation with the general practitioners and the various specialty societies in Georgia. The Council approved the motion that the Medical Association of Georgia would cooperate with the Department of Defense in implementing Public Law 569, and it was further recommended that Council Fee Schedule Committee representing the 10 districts continue its work. The Executive Committee of Council was requested to investigate costs and office procedures inherent in the Medicare fiscal program for Georgia and to report back to the Council. Mr. Sam M. Butler, Executive Director of the Blue Cross-Blue Shield Physician Service, Inc., was present and gave suggestions at this meeting. Mr. Earl Bowman of the Atlanta Blue Cross-Blue Shield group was in frequent consultation with the Headquarters Office and Executive Committee on this problem. At this special meeting of the MAG Council held October 28, 1956, after general discussion, it was moved that the Medical Association of Georgia act as its contracting agent and fiscal administrator in handling Public Law 569 and that the three Blue Shield operations in Georgia act in an advisory capacity at the discretion of both the Association and the Blue Shield Plans. A committee was set up to negotiate with the

Department of the Army in Washington, D. C., November 12, 1956, consisting of the Chairman of the Fee Schedule Committee, Charles S. Jones; Chairman of the Finance Committee, Dr. Dillinger; Chairman of Council, Dr. Chambers; the Executive Secretary, Mr. Milton Krueger; Legal Counsel, and others if found necessary. The Executive Committee of Council was designated to supervise the administration of the program, with no compensation to the members. Also set up at this time was a Medicare Review Board consisting of Charles S. Jones, Atlanta, Chairman; Sterling Claiborne, Atlanta; George Holloway, Atlanta; M. Freeman Simmons, Decatur; J. Frank Walker, Atlanta; and a member to be designated by the Georgia Medical Association. The Executive Committee also approved the hiring of Mr. Francis Shackelford, Attorney, as legal counsel for the Medicare Program.

Your committee met with the Department of the Army on November 12 and consisted of the following members: J. W. Chambers, LaGrange; Charles S. Jones, Atlanta; David Henry Poer, Atlanta; George R. Dillinger, Thomasville; Mr. Milton Krueger, Executive Secretary; and, Mr. Francis Shackelford. In the negotiations, Dr. Jones and Dr. Chambers negotiated on the fee schedule. Dr. Poer, Dr. Dillinger, Mr. Shackelford, and Mr. Krueger negotiated on the general contract. The negotiations started at approximately 8:30 a.m. and lasted until 5 p.m.

It is needless to say that on December 7, 1956, the Medicare Program for handling the claims of physicians and surgeons participating, was set-up and in operation in your Headquarters Office in Atlanta. The program is now operating successfully although there were some delays in starting payment due to the fact that the government did not, as promised, advance certain funds. The Medicare program is now processing 60 to 80 claims per day, and payment is going forward within approximately 30 days of the receipt of the bill. The Review Board has had to meet twice, and most of the claims have come within the allotted fee schedule. This is a very brief outline of the activities of your Association under Public Law 569.

Reference Committee Recommendation—Reference Committee No. 4 recommends that the report on Medicare be received for information and that the committee from Council of the Medical Association of Georgia and Legal Counsel be commended for their excellent work.

House of Delegates Action—Accepts the action of the Council report on "Medicare" as recommended by the reference committee on motion duly made and seconded.

LEGISLATION

In almost every meeting of the Council and Executive Committee, matters of legislation have been discussed. The 1957 session of the Georgia General Assembly enacted a bill giving broad powers regarding revocation and suspension of licenses by the State Board of Medical Examiners. The bill was co-sponsored by the Medical Association of Georgia and the Board of Medical Examiners. This also gives the right of injunction to the board. This type of legislation had been sponsored a number of times during the last 30 years by the physicians of Georgia so that they might police their own profession. The law is expected to provide greater protection to the public from unauthorized practices inside and outside the profession. Although the bill was weakened by an amendment sponsored by

the osteopaths, it is still a long step in the right direction. As a result of the recommendations of the Georgia Hospital Care Study Commission, a bill was passed to provide hospital care for the indigent. Also, there was a companion bill authorizing the welfare department to provide matching funds for hospital and medical care payments for welfare recipients. The so called "Heart Bill" sponsored by the MAG and the Georgia Heart Association that would have permitted employers to hire cardiacs without fear of liability under the Workmen's Compensation Law was lost in committee due to the activity of organized labor and opposition from attorneys.

Reference Committee Recommendation—Reference Committee No. 4 recommends that the section of the Council report entitled "Legislation," be accepted for information.

House of Delegates Action—Accepted the section of the Council report entitled "Legislation," as recommended by the reference committee on motion duly made and seconded.

CULTISTS

The osteopaths introduced a bill which would have permitted osteopaths complete freedom to practice medicine, surgery, and obstetrics in all their various branches. MAG opposed this bill because of the action of the House of Delegates of the American Medical Association and the action of the MAG House of Delegates defining osteopathy as a cult. The bill remained in committee due to MAG opposition, and a legislative committee is investigating osteopathic schools. Council would like affirmation of its stand by the House concerning the osteopathic cult. In two resolutions passed by you at the 1956 Annual Session, Council was instructed to employ adequate legal counsel to study and advise the medical profession regarding the status of medical practice in the State of Georgia. Pursuant to those instructions, the Legal Counsel Committee of Council after numerous discussions with the Executive Committee and with the Council itself recommended employment of the firm of Alston, Sibley, Miller, Spann and Shackelford for the purpose of determining what was legal and ethical in medical practice in the State of Georgia. This was formally approved at the September 15-16 meeting of Council. The opinion of the firm of attorneys was reported to the called MAG Council meeting of October 28, 1956. Their opinion is as follows:

Reference Committee Recommendation—Reference Committee No. 4 affirms the stand of Council defining osteopathy as a cult.

House of Delegates Action—Adopted the section of the Council report titled "Cultists," as recommended by the reference committee on motion duly made and seconded.

LEGAL OPINION RE: CORPORATE PRACTICE

September 27, 1956

Medical Association of Georgia
Gentlemen:

You have asked us to furnish you our opinion on (1) whether or not a corporation may practice medicine in Georgia, (2) whether a different rule applies to a non-profit corporation practicing medicine, (3) whether the contractual return, directly or indirectly, to a corporation by a doctor-employee of all or any part of a fee from a pay patient constitutes the corporate practice of medicine, (4) whether the return, directly or indirectly, of all or any part of a fee to a corporation by a radiologist, pathologist or

anesthesiologist employed by such corporation constitutes practice of medicine, and (5) whether or not the Eugene Talmadge Memorial Hospital is practicing medicine by collecting medical fees from pay patients even assuming it is authorized to do so by statute.

Question 1—Under the laws and decisions of Georgia, along with the laws and decisions of the overwhelming majority of other states, a corporation may not practice medicine. Pursuant to Ga. Code Ann., Section 84-907, only an individual may obtain a license to practice medicine and, in order to do so, he must furnish "evidence of good moral character", as well as proof that he is a graduate of a college of medicine "in good standing" with the State Board of Medical Examiners. The public policy reflected in the Georgia licensing statutes has a history as old as the professional status of the physicians and surgeons. Rooted in the common law itself, it is based on the principle that no professional man may hide behind the anonymity of an artificial creation such as a corporation should he fail to fulfill the exacting personal and professional standards required. While there is no Georgia decision in which a suit has been brought against a corporation in this State to restrain it from practicing medicine, there are analogous decisions in the fields of law and dentistry that lead to the conclusion that it is unlawful for a corporation to practice medicine in this state.

In *Atlanta Southern Dental College v. The State*, 51 Ga. App. 379, 180 S.E. 620 (1935), and *Rivers v. Atlanta Southern Dental College*, 187 Ga. 720, 1 S.E. 2d 750 (1939), the Georgia courts declared that the extraction of a tooth for a few cents more than the actual cost of materials or the taking of an impression and fitting of dental plates constitutes the practice of dentistry and that the defendant corporation could not practice dentistry. Likewise in *Boykin v. Hopkins* 174 Ga. 511, 162 S.E. 796 (1932), it was decided that a charter could not be granted to a corporation authorizing it to practice law in this State in any of its branches, whether the practice be confined to the courts or outside of the courts or a combination of both. One of the fundamental reasons why a corporation is not permitted to practice a learned profession was stated as follows in *re Opinion of the Justices*, 289 Mass. 606, 194 N.E. 313 (1935), striking down an attempt of a Massachusetts non-profit corporation to practice law:

"... it demands on the part of the attorney undivided allegiance, a conspicuous degree of faithfulness and disinterestedness, absolute integrity, and utter renunciation of every personal advantage conflicting in any way directly or indirectly with the interests of his client. Only a human being can conform to these exacting requirements. Artificial creations such as corporations or associations cannot meet these prerequisites."

For exactly the same reason a corporation is not allowed to practice medicine in this state.

Question 2—Having given you our opinion that a corporation may not lawfully practice medicine in Georgia, we now turn to the question of whether the practice of medicine by a non-profit corporation

is an exception to the general rule barring the corporate practice of medicine by a profit corporation. While there are no Georgia decisions on this point concerning any of the learned professions, the reason for the general rule applies with equal persuasion to a non-profit corporation and in this opinion we are supported by decisions of three other states and the opinions of Attorneys General of six additional states. Illinois: *People ex rel. Chicago Bar Ass'n v. Motorists' Ass'n of Illinois*, 354 Ill. 595, 188 N.E. 827 (1933); *People v. Association of Real Estate Taxpayers of Illinois*, 354 Ill. 102, 187 N.E. 823 (1933). Iowa: *Iowa Hospital Association v. Iowa State Board of Medical Examiners*, No. 63095 Equity, District Court of Polk County, Iowa, November 28, 1955. Massachusetts: *In re Opinion of the Justices*, 289 Mass. 606, 194 N.E. 313 (1935). California: Op. Atty-Gen. No. 48-32, May 19, 1948; Colorado: Op. Atty-Gen., May 19, 1954; Florida: Op. Atty-Gen., March 25, 1955; Idaho: Op. Atty-Gen., May 26, 1954; Ohio: Op. Atty-Gen. 1751, August 20, 1954; West Virginia: Op. Atty-Gen., June 10, 1955.

It would be too dangerous to the public interest to permit an artificial creation—a corporation—to practice medicine regardless of the fact that it is non-profit in nature. Only the moral character, reputation, responsibility and pride of a human being can suffice to protect the patient in matters so vital that they always involve his physical welfare and often even his life. A corporation because of its very anonymity would lack this all important individual responsibility regardless of the fact that such a corporation might be non-profit. The Attorney General of Colorado has pointed out that non-profit corporations have their own budget problems, and that lay administrators of such corporations may well emphasize a balanced budget so much that the corporation becomes casual if not callous towards its patients. The attorney general said on this point:

"It may also be said that the principle of control over professional activity by unlicensed personnel exists in the situation of employment of doctors by a nonprofit corporation as well as by a for-profit corporation. It may be true that the profit motive is absent in the non-profit corporation, but the profit motive is only an element which goes to the likelihood of the exercise of such control, rather than to the power to exercise such control. And we should notice the fact that the consideration of cutting costs to stay within a budget may be conducive to the exercise of such control in much the same way as is the profit motive."

Question 3—Since we have now concluded that neither a profit nor non-profit corporation may lawfully practice medicine in this state, the next question is whether the contractual return, directly or indirectly, to a corporation of all or any part of a fee by a doctor-employee of such corporation constitutes the practice of medicine by the corporation itself. It very clearly would do so in our judgment, because the employee-doctor would in reality be an agent of the corporation to which he is contractually required to return all or a part of the fee received by him from a patient. This would be as clearly the practice of medicine by the corporation as if the patient had come to the corporation itself and asked to be treated without requesting any particular doctor. It is immaterial also if the doctor-employee fails

to disclose his agency, for the evil lies in the fact that the corporation by contract—oral or written, exact in its terms or based upon a practical understanding—is acquiring all or a part of a fee from a pay patient. The Florida Attorney General ruled on this point in his opinion of March 25, 1955 saying:

"... we are bound to conclude that a corporation whether or not organized or operated for profit, may not practice medicine and surgery in this state directly because of its inability as a legal entity to obtain a license, nor can it practice indirectly by hiring licensed members of that profession to do the actual professional work involved. It is immaterial whether the compensation to the licensed person so hired be on a straight salary basis or in the form of a contractual percentage arrangement ..."

Question 4—As to whether radiology, pathology or anesthesiology constitutes the practice of medicine, we believe that these specialties clearly fall within the language of Ga. Code Ann., Section 84-906, defining the practice of medicine to include the "diagnosis or treatment of disease or injuries of human beings". While no Georgia cases have been decided on this point, it was held in *Iowa Hospital Association v. Iowa State Board of Medical Examiners*, No. 63095 Equity, District Court of Polk County, Iowa, November 28, 1955, that radiology and pathology, involving diagnosis or treatment or both, constitute the practice of medicine. Likewise the Attorney General of Idaho on May 26, 1954, ruled specifically that radiologists, pathologists and anesthesiologists practice medicine, and on June 10, 1955, the Attorney General of West Virginia made the same ruling.

Question 5—Your final question concerns whether or not the Eugene Talmadge Memorial Hospital is permitted by statute to practice medicine pursuant to special legislation authorizing it to accept "pay patients". Ga. Code Ann., Section 32-149. Assuming the answer is in the affirmative, the question then is whether it is practicing medicine as a corporation even though lawfully authorized to do so. The Talmadge Hospital is in a separate class from that of all other incorporated hospitals in the State by virtue of the law affecting it alone.

The Board of Regents in its final plans for operating the Talmadge Hospital has construed the special "pay patients" statute to mean that the hospital may in effect charge fees for medical services. So far there has been no Georgia case determining whether or not the Board's plan of operation in this respect exceeds the statutory authority of the hospital to accept pay patients. In our opinion, it does, because the special Talmadge Hospital statute must be taken in conjunction with Ga. Code Ann., Section 84-907, which limits the practice of medicine by any corporation. Quite consistent with his statute the Talmadge Hospital could accept pay patients insofar as hospitalization services are concerned. This would eliminate any possible conflict with the general statute limiting the practice of medicine to individuals, and the courts of this State as a cardinal principle of construction construe a statute, particularly an Act of special legislation, so as to avoid any conflict with prior general legislation. See *Rivers v. Atlanta Southern Dental College*, 187 Ga. 720, 1 S.E. 2d 750 (1939); *Mills v. Scott*, 99 U.S. 25 (1878); *Erwin v.*

Moore, 15 Ga. 361 (1854); *Daniel v. Citizens & Southern National Bank*, 182, Ga. 384, 185 S.E. 696 (1936).

Even if it is assumed that the Talmadge Hospital is authorized by special legislation to practice medicine it, of course, would follow that any such practice by it would constitute the corporate practice of medicine quite regardless of the fact that it was authorized by law to do so.

If there are other questions you may have, please let us know.

Sincerely yours,

FOR ALSTON, SIBLEY, MILLER, SPANN
& SHACKELFORD

/s/ F. SHACKELFORD.

Reference Committee Recommendation—Reference Committee No. 4 recommends that the House of Delegates accept for information the legal opinion on corporate practice of medicine expressed by the attorneys as reported in this section of the report of Council.

House of Delegates—Accepted the section of the report of Council titled "Legal Opinion," re: Corporate Practice, as recommended by the reference committee on motion duly made and seconded.

CORRESPONDENCE RE: R.C.M.S.

Now, gentlemen, we come to the problem that has taken up the greater part of time of every Council meeting and a great deal of the time of the House of Delegates since mid-summer 1954. That problem is the proposed operational policy of the Eugene Talmadge Memorial Hospital in Augusta, Georgia. We will not go completely into the historical background of the development of the institution, for to do so would take a review of hundreds of documents, arguments, counter-arguments, etc. The policies promulgated at that time by the president of the Medical College of Georgia and its faculty committees and approved by the Board of Regents of the University System have now been in operation for approximately a year. Those policies have never been altered, in spite of the fact that your Council of the Medical Association of Georgia and the House of Delegates have consistently pointed out that they are illegal and unethical. On May 30, 1956, letters were sent to Mr. Harmon Caldwell, Chancellor of the Board of Regents, University System of Georgia; Edgar R. Pund, President of the Medical College of Georgia; and to Mr. Robert Arnold, Chairman of the Board of Regents, University System of Georgia. These letters petitioned the Board of Regents and the President of the Medical College of Georgia as recommended in the House of Delegates resolution passed at the May 15, 1956 Session. At the called meeting of October 28, 1956, the Council approved a letter on ethics from the MAG advising the Richmond County Medical Society concerning the ethical practice of physicians employed on the teaching staff of the Medical College of Georgia in the Eugene Talmadge Memorial Hospital. The letter is as follows:

President and Secretary
Richmond County Medical Society

Assuming for the present purposes that the serving of pay patients by physicians employed by a corporation is made *legal* by Georgia Code Annotated 32-149 with respect to the Eugene Talmadge Memorial Hospital, you have asked whether it follows that such

practice falls within the Principles of Medical Ethics adopted by the Medical Association of Georgia. While we shall answer your question on the assumption stated, we should nevertheless point out that the Association's attorneys have advised us that in their opinion the Talmadge Hospital may not lawfully charge any patient for medical services. A copy of the opinion covering this and other points is enclosed for your information.

The legality of the corporate practice and the ethics of such practice are normally treated together to condemn the corporate practice of medicine. However, a legal standard may call for less than an ethical standard. Statutory law sometimes adapts itself to particular ends; the ethics of the Medical Association of Georgia, which are the same as those of the American Medical Association, deal in broad principles, admitting of no exception based on mere convenience or legal sanction.

Those broad principles are reflected in Chapter I, 1 of the *Principles of Medical Ethics of the American Medical Association*:

"The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration."

Chapter VII, 4 says:

"Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians."

That such free choice cannot exist in a corporate practice where the doctor is chosen and compensated by the corporation and the patient has no direct control over the doctor is shown by Chapter VII, 5:

"A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people."

The *Report of the Council on Medical Service* as adopted by the House of Delegates of the American Medical Association, June, 1956, says on page 8:

"We *recommend* that it be the policy of the American Medical Association that funds received from the private practice of medicine by salaried members of the clinical faculty of the medical school or hospital should not accrue to the general budget of the institution and that the initial disposition of fees for medical service from paying patients should be under the direct control of the doctor or doctors rendering the service."

At page 9, the House of Delegates added to the *Report*:

"Nothing in this Report is meant to condone the corporate practice of medicine or policies which result in the diversion of physicians' fees to a corporation or governmental agency."

It seems abundantly clear from these quotations that a hospital which accepts pay patients, receives fees for medical services, and hires the performing physician on a salary or fee percentage basis is acting outside the ethics recognized by the American Medi-

cal Association. *The Constitution and By-Laws of the Medical Association of Georgia*, as revised by the House of Delegates May 15, 1956, Chapter XII, 1, Adopts the Principles of Medical Ethics of the American Medical Association as the principles of the Medical Association of Georgia.

In addition, those County Societies in Georgia which have adopted the model Constitution and By-Laws for County Societies have adopted the language of Chapter VIII which says:

"The Principles of Medical Ethics of the American Medical Association shall govern this Society."

Whether or not Ga. Code Ann. 32-149 allows the Eugene Talmadge Memorial Hospital to accept pay patients, bill them directly for medical services, and compensate the performing physicians by salary or by giving them a percentage of the fees collected, the ethical principles of the Medical Association of Georgia clearly condemn the corporate practice of medicine. It is therefore immaterial that in a particular case corporate practice may be authorized by statute. If a doctor is an employee of a corporation that is practicing medicine or if pursuant to a contractual arrangement he is dividing his fees with a corporation, he may not be admitted to membership in the Medical Association of Georgia because to do so would be tantamount to condoning a breach of its own ethics by a doctor, who through his conduct, is enabling a corporation to practice his profession.

If the Medical Association of Georgia wishes to maintain the trust the medical profession has enjoyed historically it must not admit to membership a doctor who, innocently or otherwise, is helping a corporation violate the Association's Principles of Ethics. Its stand against the corporate practice of medicine in any form is soundly based upon the protection of both the public and itself in an area so sensitive that physical welfare and even life are always at stake. The corporate form developed and met with success because it put a shield of maximum financial liability between a businessman and the fate of his business venture. The corporate protection has worked well in the business context but has been uniformly rejected in the professions. One who furnishes professional services can have no limit put on his financial liability or on his professional honor. The professional man does not advertise; he may not hide behind the anonymity of the corporate fiction; he must risk his professional reputation on every decision he makes. For these reasons the Principles of Ethics of the Association do not tolerate corporate practice.

It is believed clear from the preceding summary of Principles of Ethics and the reasons for these principles that the Medical Association of Georgia must not admit to its membership any doctor who condones or makes possible the corporate practice of medicine whether or not such practice should have been declared by court or legislature to be legal.

Respectfully,
DAVID HENRY POER, M.D.
Secretary.

That letter was transmitted to the proper authorities of the Richmond County Medical Society, to the Asso-

ciation's Physician-Institution Relations Committee, Medical Education Committee and to the presidents and secretaries of the component county medical societies of the Medical Association of Georgia. Along with that letter went the above legal opinion concerning the legality and ethics raised by the questions to the Association Attorneys, Alston, Sibley, Miller, Spann and Shackelford.

Following this, Council was invited to hold a December MAG Council meeting in Augusta, and members of the Medical Association of Georgia Medical Education Committee, president, secretary, and governing board of the Richmond County Medical Society, president and dean of the Medical College of Georgia, and the administrator of the Talmadge Memorial Hospital were invited to attend this meeting. The Richmond County Medical Society resolution of December 11, 1956 signed by J. L. Mulherin, et al, was presented to the Council with the notation that this resolution was approved by the Richmond County Medical Society on December 11, 1956, by a vote of 30 to 29 in favor of the resolution and that the Richmond County Medical Society adopted this resolution subject to the approval of the Council of the Medical Association of Georgia. This plan was discussed some 2½ hours, free and open discussions by everyone present who desired to talk ensued. On motion, the Council requested that the Richmond County Medical Society be requested to obtain a more representative vote on the December 11, 1956, resolution in a called meeting of the society. The motion was approved. The Richmond County Medical Society met January 22, 1957, to comply with the request of Council. The Richmond County Medical Society, after discussing the December 11, 1956, resolution, then introduced the "Waters' Resolution" which was adopted on January 22, 1957, by the Richmond County Medical Society by a vote of 85 for and 23 against. On January 27, 1957, a special called meeting of the Council of the Medical Association of Georgia met in Macon, at which time the "Waters' Resolution" adopted by the Richmond County Medical Society on January 22, 1957, was presented as follows:

Reference Committee Recommendation—Reference Committee No. 4 recommends that the House of Delegates accept as information that portion of the Council report entitled "Correspondence re: Richmond County Medical Society."

House of Delegates Action—Accepted the section of the Council report entitled "Correspondence re: RCMS" as recommended by the reference committee on motion duly made and seconded.

WATERS' RESOLUTION

The "Waters' Resolution" 1/22/57

Resolution by the Richmond County Medical Society January 22, 1957, concerning the operational policies of the Eugene Talmadge Memorial Hospital.

1. *Public Relations.* All public relations by the Eugene Talmadge Memorial Hospital and the Medical College of Georgia shall be cleared through the public relations committee of the Richmond County Medical Society. This shall conform with the Code of Ethics of the American Medical Association. (From the report of the Council on Medical Service of the American Medical Association: "We recommend that publicity emanating from a medical school should be in good taste and of a type which has the approval of the general community of that area.")

2. *Liaison Committee.* A liaison committee shall be appointed to consist of five members from the Richmond County Medical Society, two members from the Council of the Medical Association of Georgia, the president of the Medical College of Georgia, and the director of the Eugene Talmadge Memorial Hospital. This committee shall be empowered to meet at appropriate intervals to investigate and to act on problems which arise between private practitioners, patients, and these institutions. Any complaints or other problems shall be referred to this committee in writing. The committee will make its report to the Richmond County Medical Society at appropriate intervals. The president of the Richmond County Medical Society shall appoint the five members from this society. The president of the Medical Association of Georgia shall appoint the two members from the Council of the Medical Association of Georgia. (From the report of the Council on Medical Service of the American Medical Association: "It is recommended that adequate liaison be developed and maintained between each county medical society and any medical school or schools in this area and between each state medical association and any medical schools in the state. Such liaison should be the primary function of some committee of the state or county medical society, and methods should be developed so as to maintain communications between medical society committees within each state.")

3. *Admissions.* It is not and shall not become the policy of the Medical College of Georgia and the Talmadge Memorial Hospital to enter into the competitive practice of medicine. Insofar as patient care is concerned, it is the purpose of these institutions, first and foremost, to care for the medically indigent of this state. Admissions of patients of unusual teaching interest shall be favored; it is realized, however, that dire emergencies and unusual circumstances will arise in which patients who are not so indigent will require the services of these institutions. No other pay (private) patient shall be admitted. This policy shall apply to both in and out patients.

The term "unusual circumstances" shall be understood to apply to those patients whose problems cannot be properly cared for through the usual private practice channels in this area. Any question or controversy arising will be referred to the Liaison Committee in writing for the committee's consideration.

No patient may be accepted by either institution except by proper referral of his *regular attending physician*.

Pay (private) patients admitted under the category of dire emergency should be transferred from the Eugene Talmadge Memorial Hospital when and if their condition permits.

4. *Fees.* Patients coming under the category of dire emergencies and unusual circumstances who are financially able to pay shall be rendered a hospital bill commensurate with the hospital charges in this area. No bill shall be rendered for the professional services; however, the patient may be invited to contribute to the research fund. These contributions should be made payable to the research fund of the

Medical College of Georgia. Use of the funds so obtained shall be for medical research purposes as recommended by a faculty committee established for this purpose. The system of collection and use of such funds shall be within the limitations of the Code of Ethics of the American Medical Association.

5. *Clinical Faculties.* It is the desire of the Medical College of Georgia and the Richmond County Medical Society to develop a strong and excellently qualified clinical faculty. Every rightful effort shall be made to develop an atmosphere in this area which will entice and keep men of such desirable qualifications.

6. *Purposes.* This resolution is made in the sincere desire to maintain and develop the high quality of medical teaching and medical care for the people of this area. This proposal is considered by the Richmond County Medical Society to be ethical and legal and all of those participating in such a program will be considered to be ethical practitioners of medicine and eligible for membership in the Richmond County Medical Society insofar as this problem is concerned.

This resolution supersedes all previous resolutions concerning the operational policies of the Eugene Talmadge Memorial Hospital.

The Waters' Resolution was approved by Council as coming within the Medical Association of Georgia Council conception of being legal and ethical. At this same meeting a resolution from the faculty was introduced by Virgil P. Sydenstricker from the faculty of the Medical College of Georgia. That resolution was accepted for information. At this January 27, 1957, special Council meeting it was moved and duly approved that a five-man committee, and president and chairman of Council as additional members, be appointed to recommend to Council what is considered ethical and legal by the Medical Association of Georgia for teaching institutions and related hospitals, and so report with this recommendation at the MAG March Council meeting. This committee met in the Headquarters Office on February 17, 1957. At the Council meeting of the Medical Association of Georgia held at Radium Springs, Albany, March 9-10, 1957, the committee made the following report concerning the application in certain cases of Principles of Ethics of the American Medical Association as adopted by the Medical Association of Georgia Council Special Medical School Ethics Committee.

Reference Committee Recommendation—Reference Committee No. 4 considered the Waters Resolution of 1/22/57. The Revised Waters Resolution as stated in Resolution No. 14 was taken as a substitute for the original Waters Resolution. The committee recommends that the House of Delegates approve the Council recommendation that the purposes stated in the Revised Waters Resolution are compatible with those stated in the Principles of Ethics of the American Medical Association as approved by Council.

House of Delegates Action—Approved this section concerning the Revised Waters Resolution as altered by the reference committee on motion duly made and seconded.

Reference Committee Recommendation—In the deliberation of Reference Committee No. 4 at this point, a resolution by the Wilkes County Medical Society which was not admissible by reason of not having been introduced at the first session of the House of Delegates was presented by A. W. Simpson, of Wilkes County, as an attempt to mediate the controversy existing between the Medical College of Georgia, the Eugene Talmadge

Memorial Hospital, and Richmond County Medical Society. (On motion made by R. C. McGahee, and seconded by Frank B. Schley, it was moved that the Medical Association of Georgia be added to the above list, and this motion carried.) The committee wishes to take this opportunity to commend the Wilkes County Medical Society for the work that they have done, and accepts the contents of the resolution to help it in its deliberations.

At this point there was some confusion as to whether or not the Wilkes County Medical Society resolution could be introduced, and the Chair ruled that Dr. Simpson was thereby appointed delegate from Wilkes County in the absence of their duly elected delegate; Dr. Simpson proceeded to introduce the Wilkes County Medical Society Resolution.

Wilkes County Medical Society Resolution

The Wilkes County Medical Society (being composed of doctors vitally interested in the operational policies of the Talmadge Memorial Hospital, in the medical education of the young men of our State, and in a harmonious and unified effort within the profession itself) has become alarmed over the schism that has developed between the Richmond County Medical Society on the one side and the Medical College of Georgia and the Eugene Talmadge Memorial Hospital on the other.

Because of this distressing situation and because the Wilkes County Medical Society has no private or personal axe to grind, it authorized at its meeting on April 16, 1957, that the following resolution be presented to the House of Delegates for consideration at its April 1957 meeting.

RESOLUTION

BE IT RESOLVED that the following be adopted by the House of Delegates of the Medical Association of Georgia:

PUBLIC RELATIONS—Inasmuch as the members of the medical staff (fulltime, part-time and clinical) of the Eugene Talmadge Memorial Hospital, are, or expect to be, members of the Richmond County Medical Society, all public relations by the Eugene Talmadge Memorial Hospital and/or the Medical College of Georgia shall be cleared through the Public Relations Committee of the Richmond County Medical Society. This shall conform with the Code of Ethics of the American Medical Association. This is understood to apply to the members and prospective members of the Richmond County Medical Society who may be connected with the Eugene Talmadge Memorial Hospital and/or the Medical College of Georgia.

LIAISON COMMITTEE—A liaison committee shall be appointed, to consist of two members from the Richmond County Medical Society, two members from the Council of the Medical Association of Georgia, two members from the Alumni Association of the Medical College of Georgia, the President of the Medical College of Georgia, and the Director of the Talmadge Memorial Hospital. This committee shall be empowered to meet at appropriate intervals to investigate and to act on problems which arise between private practitioners, patients, and these institutions. Any complaints or other problems shall be referred to this committee in writing. The committee will make its report to the Richmond

County Medical Society and to the House of Delegates of the Medical Association of Georgia at appropriate intervals. The President of the Richmond County Medical Society shall appoint the two members from his society. The President of the Medical Association of Georgia shall appoint the two members from the Council of the Medical Association of Georgia, two members of the Alumni Association of the Medical College of Georgia shall be appointed by the Speaker of the House of Delegates of the Medical Association of Georgia.

It is recommended that an advisory committee should also be appointed by the Council of the Medical Association of Georgia. This committee should consist of 10 members of the Medical Association of Georgia, one from each district medical society. Three members should be elected from each district medical society, and the Council of the Medical Association of Georgia should then select one of the three names submitted to serve on this committee. This committee should consist of the 10 persons mentioned above, the President of the Medical College of Georgia, and the Director of the Eugene Talmadge Memorial Hospital. (This committee should be empowered to meet at appropriate intervals to investigate and to act on problems which arise between private practitioners, patients, and these institutions.) This committee should act in an advisory capacity to the Board of Regents in matters pertaining to medical education. This committee will make its report to the Board of Regents and the Council of the Medical Association of Georgia at appropriate intervals, and should work in close association with the liaison committee, but one committee should not take the place of the other.

ADMISSIONS—It is not and shall not become the policy of the Medical College of Georgia and the Eugene Talmadge Memorial Hospital to enter in the competitive practice of medicine. Insofar as patient care is concerned, it is the purpose of these institutions, first and foremost, to care for the medically indigent of this state. Admission of patients of unusual teaching interest shall be favored. It is realized, however, that dire emergencies and unusual circumstances will arise in which patients who are not so indigent will require the services of these institutions. No other pay (private) patients shall be admitted.

The term "unusual circumstances" shall be understood to apply to those patients whose problems cannot be properly cared for through the usual private practice channels. Any question or controversy arising will be referred to the liaison committee in writing for the committee's consideration.

No patient may be accepted by either institution except by proper referral of his regular attending physician.

Pay (private) patients admitted under the category of dire emergencies should be transferred from the Eugene Talmadge Memorial Hospital when and if their condition permits.

It is further recommended that the admission be limited to only full residents of the State of Georgia.

FEES—Patients coming under categories of dire emergencies and unusual circumstances who are financially able to pay shall be rendered a hospital bill commensurate with the hospital charges in this area. It is

realized that the question of the manner of collection and distribution of professional fees is a moot one, both from the ethical and legal viewpoint. It is further realized that herein lies the chief obstacle to a reasonable solution of the differences between the Richmond County Medical Society and the Medical College of Georgia.

It is felt that the question of ethics should finally be settled by the Richmond County Medical Society and the Medical Association of Georgia and that the legality of the methods of handling professional fees should be finally settled by attorneys representing the Medical Association of Georgia and the Board of Regents.

To this end it is requested that the House of Delegates direct Council to instruct its attorney to consult with the attorney of the Board of Regents and the Attorney-General in order to arrive at a realistic solution of this problem. It is reasonable to suppose that the Richmond County Medical Society and the Medical College of Georgia will abide by this legal decision.

PURPOSE—This resolution is made in the sincere desire to bring about harmony within the profession and to assure proper and adequate operation of the Talmadge Memorial Hospital and the Medical College of Georgia.

At the close of the introduction of this resolution, Dr. Simpson then moved its adoption, and Speaker Goodwin asked Reference Committee No. 4 to go into executive session on this resolution and bring back to the floor of the House immediately a recommendation.

Reference Committee Recommendation on the Wilkes County Resolution—Reference Committee No. 4 recommends disapproval of this resolution on the grounds that: the manner of collection and distribution of professional fees, from an ethical standpoint, is not a "moot one" since this is adequately covered in the Principles of Ethics of the AMA and the report of the Committee on Medical School Ethics of the Council of the MAG.

House of Delegates Action—Adopted the recommendation of Reference Committee No. 4 to disapprove the Wilkes County Resolution on motion duly made and seconded.

MEDICAL SCHOOL ETHICS COMMITTEE REPORT

Application in Certain Cases of Principles of Ethics of American Medical Association as adopted by Medical Association of Georgia Council Special Medical School Ethics Committee.

The House of Delegates of the American Medical Association in June of 1956, adopted the report of the Council on Medical Services stating at the same time what the American Medical Association considers desirable concerning the practice of medicine by the faculty of a medical school, and second, what the Association considers ethical.

Whatever produces good feeling between an institution, its graduates, local doctors, and doctors in the area it serves, is desirable.

The House of Delegates of the Medical Association of Georgia accepts the principles expressed in this report of the Council on Medical Services of the American Medical Association and expresses in definite terms what is considered desirable and what will be considered ethical by the Medical Association of Georgia concerning the practice of medicine by the faculties of medical schools in the state of Georgia.

1. It is preferable that teachers who are heads of departments in medical colleges should be full-time professors, should not have private patients, and should receive all of their remuneration from a salary paid by the institution. Such professors spend their entire time in teaching, in research, and in the care of the indigent sick in the institution.

2. If for any reason these heads of departments do have private patients, they become part-time teachers just as are those others who spend part of their time in teaching, in research, and part of their time in practice on private patients, and who spend all of their time for practice, teaching, and research in the facilities of the institution and its associated institutions.

3. No college, hospital, or other institution shall practice medicine. This means that the institution must not share in any way or have any interest in fees collected for professional services. This means also that the institution shall not control or direct the doctor in his private practice or interfere in any way with the doctor-patient relationship.

4. No funds created by fees from the practice of medicine by faculty members shall accrue to the general budget of the institution.

Hospitals

The hospital of a teaching institution should be used primarily for teaching purposes and not as part of a public welfare department in the care of the indigent patients not suitable for teaching nor for custodial care of the chronically ill. The hospital of a teaching institution must not be used for the profit of the institution.

Hospitals attached to teaching institutions preferably should be limited to the number of beds required for teaching purposes, or at least should not be so large that the administration must use all possible means to keep it full.

Patients

1. All patients admitted to the hospitals of medical schools and to the clinics attached to medical schools, whether paying, medically indigent, or indigent, must be referred in writing by their private physicians, or in the case of indigent patients by some agency recognized as having authority to do so. Private pay patients must be referred only by their regular physicians and then only in writing.

2. All patients, pay or non-pay, admitted to teaching hospitals should be used for teaching purposes and should be selected as having value from this standpoint.

3. Free choice of physician must be retained and patients may be referred to or may select a specific doctor. If the patient be referred to the institution, then he must be referred by some administrative official to the chief of the department he belongs in, who will either care for the patient himself or will in turn refer him to some other doctor in his department. Patients must not be referred to individual doctors by any member of the administrative staff of the hospitals. The patient must be assigned to a physician who is responsible for his care.

4. If consultations with other doctors are necessary for diagnosis or for outlining treatment, the patient may be referred to other doctors in the hospital or clinic unless either the referring doctor or the patient has expressed a preference for other consultants.

5. If operative procedures are found to be necessary, unless it is a matter of emergency, either the patient should be sent back to his own doctor who in consultation with the patient will decide where and by whom the patient will be operated on, or the physician should be consulted by phone. In the event the patient requests operation in the hospital, the referring doctor should be consulted by phone, notified of the patient's decision and invited to be present at the operation.

6. It creates good feeling if the referring doctors are invited to visit their patients and are allowed to examine their charts while they are in the hospital.

7. Patients must be sent back to the referring doctor with a full report of the findings, diagnosis, and suggestions for treatment.

Time Consumed in Private Practice

Private practice by salaried teachers of medical colleges, teachers in hospitals or clinics associated with medical colleges, must never interfere with their teaching or research responsibilities. The relative time used for private practice and for other duties in the medical college must be agreed upon and from time to time, must be rigidly checked by the dean as of contractual relation between the medical school and the doctor individually.

Various methods have been used for limiting the time to be used in private practice.

1. Actual percentage of time allowed expressed in hours, days, or parts of days per week.

2. By accepting referred patients only.

3. By limiting the number of beds allowed in the hospital for any one doctor.

4. By limiting the amount that any teacher may earn in private practice, expressed in actual dollars or in percentage of his income.

Finances

1. Charges for the services of teachers should conform to those customary in the community, as rendered by doctors of like standing, experience and ability.

2. Charges must be made by the doctor who rendered the service.

3. Charges must be collected by the doctor who rendered the service or by a central office, but in the name of the doctor who rendered the service or of a partnership of licensed doctors but not in the name of a corporation or of any person or group of persons not licensed to practice medicine.

4. Fees collected for a doctor must be credited to the account of the doctor who rendered the service or to his department as may be agreed upon by the doctor himself.

5. Teachers having a private practice in any institution must be charged for all expenses incurred

by the institution in furnishing the facilities used in their practice if legal, and these charges must be commensurate with charges for similar services paid by other doctors in the community.

6. After the above charges are deducted, there remains a net fee fund in the name of the doctor or of the department to which he belongs. The disposition of this net fee fund must be under the control of the doctor or doctors whose services produced it. This fund must not be disposed of by contract with an institution or by direction of the institution.

If the disposition of the fund is a matter of more than one doctor in the medical school or a department of the school, it must be distributed according to an agreement between the doctors themselves totally uncontrolled by the medical school, but with the knowledge of the dean.

(a) Part of all of the net fee fund may be used to pay or to enhance the salaries of the doctors.

(b) Part or all of the net fee fund may be assigned for academic enrichment in the department, for instance, for research, for equipment, and for travel of teachers, fellows, or residents to medical meetings or for observation and study of work in other institutions, which these doctors otherwise could not afford.

(c) At the end of the year any net fee funds not expended by the above means may, with the consent of the doctors in the department, be donated to a general research fund for which the head of any department may apply. This fund must be administered by a committee composed of the doctors earning the professional fees, with the advice of the dean.

Relation of Faculties to Medical Societies

Faculty members should be members of their local society and should take an active part in the proceedings of both their county society and the state society.

Liaison Committees

1. (a) *County Society.* A liaison committee should be appointed by the local county societies to work with the dean and/or a committee from the faculty of each medical college in this area.

(b) *State Association.* A liaison committee should be appointed by the Council of the state association to work with the dean and/or a committee from the faculty of each medical college in the state. If the school be a state school, each region or district of the state should be represented and members of the various specialties in medicine should be included. Also, each state committee should have at least one member from the local county society. In general, it is wise to include on these committees some doctors who are graduates of the school and some who are not graduates of the school.

2. *Meetings.* These committees to be of service must be kept active, and the colleges must cooperate with them. They should meet at regular intervals but at least every six months, and on call for special meetings by the dean or committee chairman or by a majority of the members of the committee. A

definite number of times a year should be decided upon and adhered to for regular meetings.

3. When a medical school is contemplating some change in its policies which may cause controversies or antagonism of other doctors of the community or of the state, or of the area which it serves, the dean of the school should confer with the liaison committee, clear the action with them, and have them present the matter to their respective societies before the change is inaugurated.

4. All controversies should be settled as quickly as possible by a conference between the school authorities and the local and state liaison committees. When and if it is evident that they can't be settled by the local and state liaison committees, help should be requested of the Council of the state association which may, in turn, request assistance from the appropriate committee of the American Medical Association.

Publicity

The publicity emanating from a medical school or from a clinic attached to a medical school should be in good taste, of a type which has the approval of the local medical community, and must conform to the ethics of the American Medical Association. There should be no release to lay publications mentioning the names of individual doctors in connection with medical or organizational achievements except as may be of interest in alumni publications of the school itself.

Council Special Committee on Medical School Ethics—

J. G. McDANIEL, *Chairman*
CHARLES S. JONES
HAL M. DAVISON
CHARLES R. ANDREWS
LEE HOWARD, SR.
GEORGE R. DILLINGER
CLARENCE B. PALMER

The Council duly adopted the Medical School ethics report and *recommends to the House of Delegates its adoption thereof*. A revised Waters' Resolution of the Richmond County Medical Society was again presented to Council by Charles W. Hock, president of the Richmond County Medical Society. The Council resolved that the purposes stated in the "Revised Waters' Resolution" were compatible with those stated in the Principles of Ethics approved by the Council on this date, and it was the Council's opinion that the "Revised Waters' Resolution" presents one method by which this controversy can be solved on a local level.

At this point, we wish again to commend the energy and devotion of our president, Dr. Davison, for the monumental task of corresponding with hundreds of doctors, medical schools, and other sources concerning medical schools, hospitals, and physician relations, and correlating all of that material.

In the year 1955-56, Institution-Physician Relations Committee of Council was set up. Your House of Delegates referred a resolution on corporate practice of medicine by hospitals adopted at the 1956 session to this committee. Questionnaires concerning the relationship between the hospitals in Georgia, radiologists,

pathologists, and anesthesiologists in an effort to ascertain the working agreement between the hospital and the profession in these categories. The same type of query was sent to the hospitals in Georgia, as a further check in the above-mentioned agreements and existing arrangements. On March 9-10, at the meeting of Council, the following report was rendered by the Institution-Physician Relations Committee:

Reference Committee Recommendation—Reference Committee No. 4 recommends that the House of Delegates adopt the "Medical School Ethics Committee" report as noted in that section of the Council report.

House of Delegates Action—Adopted the section of the Council report entitled "Medical School Ethics Committee Report" as recommended by the reference committee on motion duly made and seconded.

Resolution No. 14 Revised Waters Resolution

A. J. WATERS, M.D., Augusta

BE IT RESOLVED that the following be adopted by the House of Delegates of the Medical Association of Georgia.

PUBLIC RELATIONS—Inasmuch as the members of the medical staff (full time, part-time, and clinical) of the Eugene Talmadge Memorial Hospital are, or expect to be, members of the Richmond County Medical Society, all public relations by the Eugene Talmadge Memorial Hospital and/or the Medical College of Georgia shall be cleared through the Public Relations Committee of the Richmond County Medical Society. This shall conform with the Code of Ethics of the American Medical Association. (To quote from the Council on Medical Service of the American Medical Association, "We recommend that publicity emanating from a medical school should be in good taste and of a type which has the approval of the general medical community of that area.")

This is understood to apply to the members and prospective members of the Richmond County Medical Society who may be connected with the Eugene Talmadge Memorial Hospital and/or the Medical College of Georgia.

Comment: It was the unanimous opinion of the committee drawing up this resolution that all publicity concerning the Eugene Talmadge Memorial Hospital and the Medical College of Georgia should be cleared through the Public Relations Committee of the Richmond County Medical Society. Members of the Richmond County Medical Society or any other medical organization adhere to certain policies regarding publicity, the members of the medical profession of the Eugene Talmadge Memorial Hospital and the Medical College of Georgia must be subject to the same regulations as all other members of the Richmond County Medical Society. Since the hospital was opened in June 1956, a great deal of publicity concerning the hospital and the faculty members has emanated from the public relations office of the medical school. Much of this publicity has been within ethical bounds as laid down by the American Medical Association, but is not in keeping with what is thought to be in "good taste" by the practicing physicians in this area. For example, a great many instances have occurred in which notification was put in the local papers that a physician was

going to attend a meeting and later that he had returned from attending this meeting. It has been thought by the Public Relations Committee in the past, that although such a practice is ethical, that it is not in good taste. However, if a physician goes to a meeting and takes an active part by giving a paper or presenting an exhibit, it is not only ethical but is quite desirable for the Public Relations Committee to authorize certain publicity in conformity with the Public Relations Code of the society.

According to some of the committee members who met with Drs. Pund and Payne and drew up the committee report of December 11, 1956, it was denied that the Medical College of Georgia or the Eugene Talmadge Memorial Hospital had a Publicity Department. In the *Citizens Review* on October 23, 1956, Augusta, Georgia (a copy of which is on file at the Medical Association of Georgia office), there appeared an article entitled "Augusta, a Great Hospital Center, is the Realization of 138 Year Old Dream" by Mary P. Hallinan, who is in charge of Public Relations, Medical College of Georgia. Miss Hallinan's picture appeared in this article.

The committee referred to above also reported that Dr. Edgar Pund has given his approval to an article which appeared in the handbill of the Augusta Players, "The Crucible," November 19 through 24, 1956. This appeared on page 6 of the handbill opposite the "Synopsis of Scenes." (A complete copy of the handbill is on file at the Medical Association of Georgia headquarters.) It is such publicity as this that has made the committee feel that *all publicity* concerning the Medical College of Georgia and the Eugene Talmadge Memorial Hospital should be cleared through the Public Relations Committee of the Richmond County Medical Society.

Page 6, Augusta Players Handbill:

"The Eugene Talmadge Memorial Hospital has been open less than six months. In that brief period, the most amazing body of fact and fancy has accumulated. Let's examine just a few of these facts and fancies.

"Is it true that you can't get into the Eugene Talmadge Memorial Hospital if you live in Richmond County? Not true. The hospital is open to all citizens of Georgia on the same basis, that is, you must be referred by your family physician or an authorized medical agency.

"Is it true that the finest medical facilities in the Southeast are not available to you if you live in South Carolina? Not true. Anybody in the world can be referred to and admitted to the hospital, however, the entire expenses of a non-Georgian must be guaranteed before he can be accepted as a patient.

"Is it true that there are no private rooms and no wards in Eugene Talmadge Memorial Hospital? Essentially true. The colorful two and four-bed rooms are of the most modern design for both the mental and physical welfare of the patient and efficient utilization of the time and abilities of the staff. Great care is taken to put patients of similar interests and tastes in the same room. Every room has piped-in oxygen and a private commode and lavatory. These features increase both the comfort and safety of the patient.

"Is it true that this 850 bed hospital has only about 140 beds occupied at present? True. A new hospital like a new automobile design requires testing and breaking in. Will the features that looked so good on paper be acceptable in reality? Are many of the features so revolutionary that the staff needs time to study and evaluate them? This breaking-in period has proceeded quite smoothly at Eugene Talmadge Memorial Hospital, and operations are gradually expanding. The hospital requires over 300 nurses to operate at full capacity, at present it has only 50. In the face of the severe shortage of nurses in the United States, the assembling of this large number of essential personnel is a slow and arduous process. In fact, complete staffing of the hospital will require about 1,500 people, all of the highest degree of character and competence, and most of them with advance technical training. It is not possible to find these people overnight. Progress in this direction has been and continues to be slow.

"Is it true that every patient admitted to Eugene Talmadge Memorial Hospital is a teaching patient? True. One of the most vital necessities in the training of a doctor is his exposure to a large number of patients and a wide variety of illnesses. The step from learning to doing is a hard one, but doing must be ingrained in the would-be physician. This policy is directed at benefiting Georgia citizens in two ways, first, providing the best treatment for the immediate patient; second, providing better trained doctors for future patients'.

"There is one more question that should be asked. Why is there so much confusion in regard to this splendid addition to Augusta's medical and economic resources? Numerous lengthy articles have appeared in the daily papers. Voluminous articles in the *Citizens Review* described in detail not only the policies, operational procedure, and equipment of Eugene Talmadge Memorial Hospital but of all the medical facilities in Augusta. Perhaps these articles are too lengthy for easy reading, but, if you are interested in your health, they provide an excellent opportunity for learning just what outstanding medical care is available to you without ever leaving home."

LIAISON COMMITTEE—A Liaison Committee shall be appointed to consist of five members from the Richmond County Medical Society, two members from the Council of the Medical Association of Georgia, the President of the Medical College of Georgia, and the Director of the Eugene Talmadge Memorial Hospital. This committee shall be empowered to meet at appropriate intervals to investigate and to act on problems which arise between private practitioners, patients, and these institutions. Any complaints or other problems shall be referred to this committee in writing. The committee will make its report to the Richmond County Medical Society at appropriate intervals. The President of the Richmond County Medical Society shall appoint five members from this society. The President of the Medical Association of Georgia shall appoint the two members from the Council of the Medical Association of Georgia. (Quotation from the report of the Council on Medical Service of the American Medical Association: "It is recommended that

adequate liaison be developed and maintained between each county medical society and any medical school or schools in its area and between each state medical association and any medical schools in the state. Such liaison should be the primary function of some committee of the state or county medical society, and methods should be developed so as to maintain communication between medical society committees within each state.”)

It is recommended that an advisory committee should also be appointed by the Council of the Medical Association of Georgia. This committee should consist of 10 members of the Medical Association of Georgia, one from each district medical society. Three members should be elected from each district medical society, and the Council of the Medical Association of Georgia should then select one of the three names submitted to serve on this committee. This committee should consist of the 10 persons mentioned above, the President of the Medical College of Georgia, and the Director of the Eugene Talmadge Memorial Hospital. (This committee should be empowered to meet at appropriate intervals to investigate and to act on problems which arise between private practitioners, patients, and these institutions.) This committee should act in an advisory capacity to the Board of Regents in matters pertaining to medical education. This committee will make its report to the Board of Regents and the Council of the Medical Association of Georgia at appropriate intervals, and should work in close association with the Liaison Committee from the Richmond County Medical Society, but one committee should not take the place of the other.

Comment: It was the opinion of the committee drawing up the resolution that this committee and a similar committee appointed by the Medical Association of Georgia is the basis for success in the operation of the proposed plan. The Medical College of Georgia and the Eugene Talmadge Memorial Hospital officials have repeatedly said that they cannot and will not be police officers and judge who should and should not enter the hospital when the patient is referred by a licensed physician. Since that is the attitude and opinion of these officers, it is felt that the Liaison Committee and Advisory Committee should review the admissions to the Eugene Talmadge Memorial Hospital at regular intervals so that it can be ascertained as to whether or not the admission policies are being carried out. It is felt that these policies can only be effectively carried out through the cooperation of the officials of the Medical College of Georgia and the Eugene Talmadge Memorial Hospital.

ADMISSIONS—It is not and shall not become the policy of the Medical College of Georgia and the Eugene Talmadge Memorial Hospital to enter into the competitive practice of medicine. Insofar as patient care is concerned, it is the purpose of these institutions, first and foremost, to care for the medically indigent of this state. Admission of patients of unusual teaching interest shall be favored. It is realized, however, that dire emergencies and unusual circumstances will arise in which patients who are not so indigent will require the services of these institutions. No other pay (private) patients shall be admitted. This policy shall apply to both in and out patients.

The term “unusual circumstances” shall be understood to apply to those patients whose problems cannot be properly cared for through the usual private practice channels. Any question or controversy arising will be referred to the liaison committee in writing for the committee’s consideration.

No patient may be accepted by either institution except by proper referral of his *regular attending physician*.

Pay (private) patients admitted under the category of dire emergencies should be transferred from the Eugene Talmadge Memorial Hospital when and if their condition permits.

Comment: The term “regular attending physician” was emphasized in the referral plan because on several occasions when the patient’s regular attending physician refused for various reasons to refer a patient to the Eugene Talmadge Memorial Hospital, the patient then sought out other doctors who would give him a referral slip.

It is also the opinion of the committee, which was supported by the Richmond County Medical Society, that those patients admitted under the term “dire emergencies” should be transferred from the Eugene Talmadge Memorial Hospital as soon as the emergency ceases to exist, and that the patient’s condition could be properly cared for by other institutions.

It is further recommended that admission be limited to only full residents of the State of Georgia.

FEES—Patients coming under categories of dire emergencies and unusual circumstances who are financially able to pay shall be rendered a hospital bill commensurate with the hospital charges in this area. No bill shall be rendered for the professional services; however, the patient may be invited to contribute to the Research Fund. These contributions should be made payable to the Research Fund of the Medical College of Georgia. Use of the funds so obtained shall be for medical research purposes as recommended by a faculty committee established for this purpose. The system of collection and use of such funds shall be within the limitations of the Code of Ethics of the American Medical Association.

However, the question of professional fees shall be settled finally in regard to legal matters by attorneys representing the Medical Association of Georgia and the Board of Regents; and the question of medical ethics shall be settled by the Council of the Medical Association of Georgia.

Comment: A great deal of thought and consideration went into the preparation of this paragraph. The attorney for the Medical Association of Georgia, Mr. Francis Shackelford, advised us that if the Medical College of Georgia or the Eugene Talmadge Memorial Hospital charged any fees for the services of the physician, that in his opinion this would constitute the corporate practice of medicine and would be illegal, and it would also be unethical for a member of the Medical Association of Georgia to participate in this program. After consulting with Mr. Shackelford, it was thought best to render no bills for physician services, but the patient could be invited to donate to the Research Fund of the Medical College of Georgia in its place. This is both legal and ethical. It was the committee’s opinion and the opinion of Mr. Shackelford that if the private

(pay) patients were confined strictly to the terms as outlined under the paragraph on admissions, the number of such patients should be quite minimal and that the pay angle should not be controversial factor.

The problem of legality of collection of fees is beyond the scope of this committee and should be handled by legal advisors of the Medical Association of Georgia.

Furthermore, the committee would like to point out that the patients coming into the hospital under "unusual circumstances" or "dire emergencies" should pay hospital fees which are commensurate with the hospital charges or fees in this area, rather than to pay on the per diem rate as is presently done. Today the tax-payer of Georgia is paying for the hospitalization of the private (pay) patient.

We are told by local hospital authorities that a per diem rate of \$25.00 the first day and \$15.00 each additional day is totally unrealistic, and that a truer rate would be almost twice as much to cover *all* hospital and laboratory expenses. It is unfair for the taxpayer of Georgia to pay these additional hidden costs for the private (pay) patients from Georgia or from other localities. It is reported that private patients are already saying that they can go to the Eugene Talmadge Memorial Hospital and have everything plus paying the professional fee, for no more than they would pay for a semi-private room alone at the other local facilities. It is apparent that if this be true, the cost is being absorbed by the tax-payers.

CLINICAL FACULTY—It is the desire of the Medical College of Georgia and the Richmond County Medical Society to develop a strong and excellently qualified clinical faculty. Every rightful effort shall be made to develop an atmosphere in this area which will entice and keep men of such desirable qualifications.

PURPOSE—This resolution is made in the sincere desire to maintain and develop the highest quality of medical teaching and medical care for the people of this area. This proposal is considered by the Richmond County Medical Society to be ethical and legal, and all those participating in such a program will be considered to be ethical practitioners of medicine and eligible for membership in the Richmond County Medical Society insofar as this problem is concerned.

At the regular meeting of the Council of the Medical Association of Georgia held at Radium Springs, Albany, Georgia, March 9th and 10th, the following resolution, introduced by Thomas W. Goodwin and seconded by Hal M. Davison was passed: It was moved that the Council of the Medical Association of Georgia thank the Richmond County Medical Society for its efforts in working out the differences in the Talmadge Hospital controversy and that the Council appreciate these efforts that went into the formation of the Revised Waters Resolution and that the Council further resolve that the purposes stated in the Revised Waters Resolution are compatible with those stated in the principles approved by Council this date, and it was further moved that it be the Council's opinion that the Revised Waters Resolution represents one method by which this controversy can be solved on a local level.

Reference Committee Recommendation—Reference Committee No. 4. Resolution No. 14, on Revised Waters Resolution. Recommends that the House of Delegates accept this resolution as being ethical.

House of Delegates Action—It was moved (A. J. Waters, Augusta; David R. Thomas, Jr., Augusta) that the House of Delegates adopt the Revised Waters Resolution with the following alterations:

(1) Delete all Comments.

(2) Delete the following under the sub-heading of Fees: "No bill shall be rendered for the professional services; however, the patient may be invited to contribute to the Research Fund. These contributions should be made payable to the Research Fund of the Medical College of Georgia. Use of the funds so obtained shall be for medical research purposes as recommended by a faculty committee established for this purpose. The system of collection and use of such funds shall be within the limitations of the Code of Ethics of the American Medical Association." Also delete the word "however" in the sentence following the above deletion, and begin the sentence with the words "the question of professional fees . . ."

(3) Add the following sentence to the section on fees in the Revised Waters Resolution: "It is requested that Council be directed to instruct its attorneys to consult with the attorneys of the Board of Regents, and the Attorney General to finally settle this question legally."

The motion to adopt the Revised Waters Resolution, No. 14, as altered above was approved by the House.

MAG—Adopted Waters Resolution

"BE IT RESOLVED that the following be adopted by the House of Delegates of the Medical Association of Georgia.

"PUBLIC RELATIONS—Inasmuch as the members of the medical staff (full-time, part-time, and clinical) of the Eugene Talmadge Memorial Hospital are, or expect to be, members of the Richmond County Medical Society, all public relations by the Eugene Talmadge Memorial Hospital and/or the Medical College of Georgia shall be cleared through the Public Relations Committee of the Richmond County Medical Society. This shall conform with the Code of Ethics of the American Medical Association. (To quote from the Council on Medical Service of the American Medical Association, 'We recommend that publicity emanating from a medical school should be in good taste and of a type which has the approval of the general medical community of that area'.)

"This is understood to apply to the members and prospective members of the Richmond County Medical Society who may be connected with the Eugene Talmadge Memorial Hospital and/or the Medical College of Georgia.

"LIAISON COMMITTEE—A liaison committee shall be appointed to consist of five members from the Richmond County Medical Society, two members from the Council of the Medical Association of Georgia, the President of the Medical College of Georgia, and the Director of the Eugene Talmadge Memorial Hospital. This committee shall be empowered to meet at appropriate intervals to investigate and to act on problems which arise between private practitioners, patients, and these institutions. Any complaints or other problems shall be referred to this committee in writing. The committee will make its report to the Richmond County Medical Society at appropriate intervals. The President of the Richmond County Medical Society shall appoint five members from this society. The President of the Medical Association of Georgia shall appoint the two members from the Council of the Medical Association of Georgia.

"It is recommended that an advisory committee should also be appointed by the Council of the Medical Association of Georgia. This committee should consist of 10 members of the Medical Association of Georgia, one from each medical district society. Three members should be elected from each medical district society, and the Council of the Medical Association of Georgia should then select one of the three names submitted to serve on this committee. This committee should consist of the 10 persons mentioned above, the President of the Medical College of Georgia, and the Director of the Eugene Talmadge Memorial Hospital. (This committee should be empowered to meet at appropriate intervals, to investigate and to act on problems which arise between private practitioners, patients, and these institutions.) This committee should act in an advisory capacity to the Board of Regents in matters pertaining to medical education. This committee will make its report to the Board of Regents and the Council of the Medical Association of Georgia at appropriate intervals, and should work in close association with liaison committee from the Richmond County Medical Society, but one committee should not take the place of the other.

"ADMISSIONS—It is not and shall not become the policy of the Medical College of Georgia and the Eugene Talmadge Memorial Hospital to enter into the competitive practice of medicine. Insofar as patient care is concerned, it is the purpose of these institutions, first and foremost, to care for the medically indigent of this state. Admission of patients of unusual teaching interest shall be favored. It is realized, however, that dire emergencies and unusual circumstances will arise in which patients who are not so indigent will require the services of these institutions. No other pay (private) patients shall be admitted. This policy shall apply to both in and out patients.

"The term 'unusual circumstances' shall be understood to apply to those patients whose problems cannot be properly cared for through the usual private practice channels. Any question or controversy arising will be referred to the liaison committee in writing for the committee's consideration.

"No patient may be accepted by either institution except by proper referral of his regular attending physicians.

"Pay (private) patients admitted under the category of dire emergencies should be transferred from the Eugene Talmadge Memorial Hospital when and if their condition permits.

"It is further recommended that admission be limited to only full residents of the State of Georgia.

"FEES—Patients coming under categories of dire emergencies and unusual circumstances who are financially able to pay shall be rendered a hospital bill commensurate with the hospital charges in this area.

"The question of professional fees shall be settled finally in regard to legal matters by attorneys representing the Medical Association of Georgia and the Board of Regents; and the question of medical ethics shall be settled by the Council of the Medical Association of Georgia. It is requested that Council be directed to instruct its attorneys to consult with the attorneys of the Board of Regents and the Attorney General to finally settle this question legally.

"CLINICAL FACULTY—It is the desire of the Medical College of Georgia and the Richmond County Medical Society to develop a strong and excellently qualified clinical faculty. Every rightful effort shall be made to develop an atmosphere in this area which will entice and keep men of such desirable qualifications.

"PURPOSE—This resolution is made in the sincere desire to maintain and develop the highest quality of medical teaching and medical care for the people of this area. This proposal is considered by the Richmond County Medical Society to be ethical and legal, and all those participating in such a program will be considered to be ethical practitioners of medicine and eligible for membership in the Richmond County Medical Society insofar as this problem is concerned."

INSTITUTION-PHYSICIAN RELATIONS

Report of Institution-Physician Relations Committee

In the Spring of 1956 questionnaires concerning the relationship between the hospitals of Georgia and radiologists, pathologists, and anesthesiologists were sent to these groups of specialists in Georgia, and to 224 hospital administrators. Replies were received from approximately 20 per cent of the hospitals, 25 per cent of the anesthesiologists, 30 per cent of the radiologists, and 50 per cent of the pathologists. The replies were tabulated and a complete summary is attached to this report.

The replies to the questionnaires were studied, discussed, and summarized by the committee.

It is apparent from this survey that some physicians in Georgia are employed by private hospitals on a straight salary basis. In the opinion of the committee such an arrangement constitutes the corporate practice of medicine and lends itself to exploitations of physicians by hospitals. It is considered unethical for a physician to have this type of arrangement with a hospital that admits private patients. (This, of course, does not apply to internes and residents.)

It is common practice in two of the specialties

concerned in those questionnaires, i.e., radiology and pathology, for a physician to have an employment contract with a private hospital whereby the physician receives a certain percentage of the receipts of his department. It is considered ethical for a physician to have this type of arrangement with a hospital if: (1) he makes certain that there is sufficient professional coverage at all times to assure high quality and efficient service, and (2) provided that the hospital bill clearly indicates that a percentage of the fee is for professional service. (In the interest of maintaining patient-physician relationship, it is desirable to have the name of the physician concerned on the hospital bill, although it is realized that it is not always feasible, particularly for larger hospitals.)

The committee feels very strongly that the same rules of ethics should apply to all physicians of Georgia.

This report was approved by Council and Council recommends its adoption by the House of Delegates.

Reference Committee Recommendation—Report of the Institution-Physicians Relations Committee of Council. Reference Committee No. 4 commends the members of this committee and recommends that the House of Delegates adopt the report.

House of Delegates Action—Adopted the report of the Institution-Physicians Relations Committee of Council as recommended by the reference committee on motion duly made and seconded.

MEDICAL DEFENSE

Medical Defense Activities. Section 3 (c), Chapter X, Standing Committees of the 1956 Revision of the By-Laws last paragraph, states that the committee shall, on the advice of Council in cases being worthy of defense furnish the services of the Association Counsel for the purpose of consultation and advice relative to threatened or actual litigation provided the Association does not assume financial obligation in excess of \$100 for any one member in any one calendar year. Any charge or fees in excess of \$100 for any one member in any calendar year shall be borne by the member requesting the privilege of medical defense consultation and advice as stated herein. This problem was discussed at the June 3, 1956, Council meeting, and it was moved that the membership of the Medical Association of Georgia be notified as to why the privileges of medical defense have been altered and to inform them about the new provisions of medical defense and to further query these members as to whether or not they carry their own professional liability insurance. At the Executive Committee meeting July 1, 1956, it was approved that the notice of the recent change regarding the medical defense privileges should appear in the *Journal* rather than mailing a letter to every member of the Association. A bill for attorney's fee for the defense of a member of the Association in a suit filed March 16, 1954, has been received. The attorney's fee is \$1,250. The case resulted in mistrial and is to be re-tried. After discussion by the Medical Defense Committee it was found that the Association was obligated because we could not make the change in the By-Laws retroactive. This case still has to be tried and there are three other cases pending. Before these three or four cases are finally cleared up, the Association may be obligated for several thousand dollars.

Reference Committee Recommendation—Reference Committee No. 4 recommends that the House of Delegates accept the report of

Council Committee on Medical Defense activities for information.
House of Delegates Action—Accepted the report of Council Committee on Medical Defense activities as recommended by the reference committee on motion duly made and seconded.

INSURANCE AND ECONOMICS

The Insurance and Economics Committee worked out a revision of the Georgia Plan which was approved July 1, 1956, by Executive Committee of Council for promulgation and putting into effect. The Insurance and Economics Committee presented a resolution to Council at the December 15-16 Council meeting, 1956. It was moved that Insurance and Economics Committee recommend to the MAG Council that membership of the Medical Association of Georgia be included under the present Federal Social Security program OASI Title II. After discussion, this motion was unanimously approved with the request that it be written into the minutes that approval was given reluctantly to the principles involved in the present social security program. The motion was discussed by Council and referred by Council to the House of Delegates for action.

The professional liability group insurance recommended by the Insurance and Economics Committee and put into effect in 1955-56 with the St. Paul—Mercury Company now has over 1,400 members of the MAG covered with liability insurance. The program is beginning to "pay-off" for there was a reduction of 10 per cent in premium payments in 1956 while the "old line" firms raised rates during this period. Council requests that all members of the Medical Association of Georgia support this program.

Reference Committee Recommendation—Reference Committee No. 4 recommends that the House of Delegates approve Council's recommendation that all members support the professional liability group insurance program.

House of Delegates Action—Adopted the recommendation that the House of Delegates approve Council's recommendation that all members support the professional liability group insurance program on motion duly made and seconded.

ANNUAL SESSION

The Annual Session Committee under the able direction of J.G. McDaniel, Atlanta, has left no stone unturned to provide the best possible program for this 1957 Annual Session. At every meeting of Council, problems for the Annual Session have been discussed. Council appreciates the excellent cooperation that we have had from the Local Arrangements Committee in Savannah. They are to be commended for their interest and activity.

Reference Committee Recommendation—Reference Committee No. 4 wishes to commend the Annual Session Committee of Council and accepts their report for information.

House of Delegates Action—Accepted the Annual Session Committee of Council report as recommended by the reference committee on motion duly made and seconded.

BUILDING COMMITTEE

During the past year, our Headquarters Building Committee has been very active. The problem has been discussed in Council many times. The committee has met with the committee of the Fulton County Medical Society, but to date, no progress has been made. Our Association headquarters, due to increased activity, is now utilizing all available floor space and greatly needs more to function efficiently. Your Council would appreciate recommendations from the House of Delegates.

The activities and reports of the Veterans' Affairs Committee have been studied by Council. Veterans' Affairs as related to medical care is an ever recurring problem and as usual, it is a political "pork barrel." We wish to commend Hartwell Joiner and his Veterans' Affairs Committee for their activity. Council has implemented the funds of the Veterans' Affairs Committee and requested a study of the situation in Georgia, and we hope to have something to report to you at this annual session.

Reference Committee Recommendation—Reference Committee No. 4 commends the Building Committee for its activities for the past year but has no further recommendation.

House of Delegates Action—Received for information only the Building Committee report and the recommendation of the reference committee.

HISTORY AND VITAL STATISTICS

The History and Vital Statistics Committee of the Association, particularly the Chairman, J. Calvin Weaver, is preparing a history of medicine in Georgia. Your president set up a special committee to study this manuscript and material. The special committee reported to Council that this material was well worthy of publication. However, manuscript preparation is in progress. Council allotted funds for secretarial help to the committee. Dr. Weaver is to be congratulated on the excellent job that he is doing.

Reference Committee Recommendation—Reference Committee No. 4 recommends that the House of Delegates authorize Council to support J. Calvin Weaver in the writing and publishing of a "History of Medicine in Georgia."

House of Delegates Action—Adopted the section of the Council report titled "History and Vital Statistics" as recommended by the reference committee on motion duly made and seconded.

PUBLIC SERVICE COMMITTEE

The Public Service Committee of the Association has been very active. The chairman has attended most of the Council meetings and reported on the activities. Council wishes to commend Chris J. McLoughlin and his Public Service Committee for their diligence and interest in Association activities and the excellent work that they are carrying on. The chairman of this committee also represents the Association on the Inter-Professional Council.

We could continue indefinitely concerning the activities of physicians who participate in the work of the Association, but time and space prevent our continuing.

Again, I wish to thank the members of Council who have so diligently and faithfully attended the meetings and given serious consideration to every problem. The officers of your Association during 1956-57 we wish again to commend for their unselfish devotion and hard work.

Reference Committee Recommendation—Reference Committee No. 4 wishes to commend the Council of the Medical Association of Georgia for its excellent work as well as its informative report and recommends approval of the report of Council as a whole.

House of Delegates Action—Adopted the report of the Council as a whole with the section by section action noting corrections, additions and deletions, on motion duly made and seconded.

Medical Education Committee

R. C. MCGAHEE, M.D., Augusta, *Chairman*

A meeting of this committee was held soon after its appointment. It was obvious that the first duty of this

committee was to aid in any and every way possible to bring about better relations between medical education and medical practice in our state. These problems existed at both Emory and the Medical College of Georgia. The controversy concerning the operational policy of the Eugene Talmadge Memorial Hospital has not been solved, and we feel that this problem has resulted in serious hurt to relations between the medical educators and the practitioners of medicine.

In order that the problems might be more closely studied and solved if possible, separate committees were set up, one in each school area. Each committee was to have a representative of the school, an alumnus, a member of Council, and a member from the Education Committee of the Medical Association of Georgia.

C. F. Stone, Jr., of Atlanta, represented the Education Committee on the Emory committee, and R. C. McGahee, the Medical College of Georgia Committee.

Dr. Stone's statement is a part of this report.

Concerning the operational policy of the Eugene Talmadge Memorial Hospital, this subcommittee has worked closely with Council of the Richmond County Medical Society in trying to find some ethical and legal plan agreeable to all. It is felt that some progress has been made, but as of now final agreement has not been reached. At times a solution appeared at hand only to find that seeming accord had failed. It is hoped that good minds and good will may reach an answer. The problem is placing friend against friend and medical educators against medical practitioners which breeds no good for either.

This committee notes with interest the formation of Student AMA Chapters in our schools. The purpose of this organization is to bridge the gap between medical education and medical practice. Through an advisory committee the students are instructed in the proper approach to their practicing of medicine. These include ethics, economics, choice of location as well as the responsibility of the physician in the community as a citizen. This training should give us better adjusted physicians.

This student movement should have the support of organized medicine. This may include some financial support.

The whole realm of medical education and medical practice is undergoing an evolution. This committee has great responsibility to see that the best tradition of both are maintained and that things new be for the good of all — education, practice, and the best medical care of our people.

Comments on 53rd Annual Congress on Medical Education and Licensure: A report by the MAG representative, February 9-12, 1957, Palmer House, Chicago, are as follows:

The general subject at this meeting was the importance of postgraduate medical training both at the intern, resident, and practicing physician level.

Hugh Lokey, Dean, Cornell Medical College, discussed the role of undergraduate medical education and preparation for the graduate level, and emphasized practical application and correlation.

William B. Hildebrand, former president of the American Academy of General Practice, urged more facilities for general practice residencies.

William Bean, Professor of Medicine, State University of Iowa, stated that they had discontinued their general practice program because of lack of applicants for this type training, as well as Army interference and the fact that after a certain amount of training, usually the house officers that he had encountered then decided to go into some specialty.

Charles Puestow, Professor of Surgery, University of Illinois, emphasized that a person needs at least two years minimum rotating internship to be prepared to do even minor surgery. He stated that only 2½ per cent of the residencies in the country were available for general practice training, yet 65 per cent of physicians in the country are in general practice. He objected to programs set up to benefit the hospital and not for educational standards themselves. This thought of utilizing house staffs for what you could get out of them was recurrent through most of the talks and everyone felt that the problem emphasis should be on training, education and improvement of the patient care rather than an "arms and legs" attitude toward the house staff.

There was then general panel discussion of the whole problems and it was felt that at least two years minimum should be required internship of a rotating type for general residency approval, the prime objective being development of judgment and skills, enabling the general practitioner to take care of those things of which he was capable and yet to recognize those conditions that required more definitive care.

During the course of the discussion, it was pointed out that it was contrary to AMA feelings to restrict hospital privileges to board people. They seemed to have the feeling that "merit alone", as determined by the staff of the hospital concerned, should be the criterion determining how much a given person should be allowed to do in more difficult matters.

Glenn R. Shepherd, Assistant Secretary for the Council on Medical Education in Hospitals, first outlined difficulties with some programs that have not been approved under three categories: (1) lack of real objectives, (2) lack of a medical co-ordinator who is in charge of the program, and (3) the frequent need for periodic appraisal by the staff concerned, as well as by proper objective criteria. His group is now preparing a definition of a good, sound program which is being gotten together with consultants from the American Medical College Association, The American College of Physicians, The American College of Surgeons, etc. This definition will be submitted to the AMA for approval. But he did not list the points contained in it now. (1) That all the meetings should be primarily educational. (2) The information at these meetings should be made readily available to everyone interested. (3) The need for more basic science information, particularly as applied to patient care. (4) Development of critical judgment on the part of the staff. (5) That the program be administered by a respected director of medical education. This is necessary to have continuity of educational process as well as to allow for advance planning and to obtain the participation of practicing physicians. (6) An adequate budget for this program should be available. (7) The program

should be such that the participating doctors in the hospital take an active part in it.

He thought it was essential that the practicing physicians in the hospital should have a voice in organizing the program so that it would meet the needs and wishes of the staff, as well as be concerned with more recent advances in medical knowledge.

He stated that available facilities must be adequate, such as libraries, records, patients to discuss, audio-visual aids, etc. He thought that methods of teaching should be varied consisting of a few lectures, mostly panel discussions, plus live clinics on patients, bedside teaching rounds, and questions and answers.

He pointed out the difficulties the council has in really evaluating a good program, but the above criteria are among those they feel should be met.

He further stated that the council wants to serve as a clearing-house for information on the above and would be happy to cooperate in answering any questions or making any suggestions that they could.

Barry Wood, Vice-President of Johns Hopkins Medical Institutions, discussed the "underlying cause of unrest in university medicine" and felt that the rapidly changing dimensions of medical science, caused difficulties in communication.

He pointed out that the detailed information necessary to really understand principles of physical chemistry involved mathematic calculations and detailed biological phenomena added to specialization in compartmentation. He also mentioned the inter-relationships of the individual to his environment which broadens out to such an extent that it makes people in this phase of medicine quite strangers to others in the more basic fields.

He hopes that some method would be found whereby the educational process could be shortened rather than continually lengthened as it is now to the point at which a person is almost ready to retire by the time he gets through with his formal education. He had no quick answer to this problem, but stated that studies in this direction are being carried out.

Edwin W. Dempsey, of Washington University School of Medicine, discussed some of the financial difficulties involved in long periods of training and pointed out that there are some grants available for summer research training aid to medical students.

One of the most interesting descriptions of a well run postgraduate program, on a statewide level, was given by M. H. Delp, Professor of Medicine, University of Kansas. Apparently he was able to get the medical school, the state society, and the state public health agencies to work together in evolving a postgraduate educational program on a statewide level. They have had from two to three thousand physicians participate and have met with a great deal of success.

Harry Towsley, Coordinator of Affiliated Hospital Activities, University of Michigan, described the Michigan plan which has been successfully in operation now for quite a few years and was originally started by Kellogg Foundation money.

Charles F. Wilkinson, Jr., Professor-Chairman of Dept., New York University Postgraduate Medical School, described their plan of postgraduate hospital

affiliation. In this set-up the university sends teams to the affiliating hospitals three times a week the first year, twice a week the second year, and once a week the third year. The philosophy behind this being that at the end of three years, the hospitals themselves should have improved their graduate training process to such an extent that they could carry on their own, drop out of the plan and make room for another hospital that needs help.

The annual meeting of the Association Hospital Directors was also held February 10, 1957, and it was generally felt that a visiting physician program alone was usually ineffective. However, it was pointed out that probably the best level of teaching comes on informal contact between the teaching physician and the house staff, if they will discuss with each other the patient's problems.

The "medical audit" came up for a good bit of discussion, being presented by Virgil Slee of Ann Arbor, Michigan. This consists of picking out certain information from the charts that can be subjected to statistical analysis so that a hospital can find out where it stands in terms of deaths, operations, with regard to pathology of tissue found at operation, days of illness from various categories, x-rays taken in relationship to patients with pneumonia, etc. This plan is simply one in which the hospital can see how it stands and then its own tissue committee or inter-audit committee can investigate those areas which seem to be out of line with most other people. There are interesting reprints on this available, if one is interested.

Reference Committee Recommendation—Reference Committee No. 4 recommends that the House of Delegates accept the report of the Medical Education Committee for information.

House of Delegates Action—Accepted the Medical Education Committee report as recommended by the reference committee on motion duly made and seconded.

ADDENDUM NO. 2—MEDICAL EDUCATION COMMITTEE

CHARLES F. STONE, JR., M.D.

The Emory Liaison Subcommittee was established to aid in bringing about better understanding and better relations between Emory medical educators and Georgia practicing physicians. Whether anything worthwhile has been accomplished remains for the future to decide. It is felt that a beginning has been made and the following activities were participated in by various members of this subcommittee.

1. An informal meeting September 16, 1957, with H. B. Cason and several interested parties.
2. An official four hour meeting September 20, 1956, with Hal M. Davison, Arthur P. Richardson, David Henry Poer, J. Elliott Scarborough, H. B. Cason, and myself. Minutes of this meeting have been previously submitted.
3. Conference November 29, 1956, with the legal counsel of Emory University, Emory Diagnostic Clinic, and the Medical Association of Georgia, at which the problem of corporate practice of medicine was discussed. No general agreement was reached, and the matter is still being actively pursued by the lawyers concerned.
4. Most of the committee members attended a dinner meeting January 24, 1957, where Emory's policies and goals were defined by University Vice-President Jones.

5. January 21, 1957, the Fulton County Medical Liaison Committee heard the dissatisfied members of the medical faculty give their views of the controversy.

6. In February 1957, the Hospital Authority and Grady Hospital Superintendent, Mr. Frank Wilson, stated their views.

7. March 21, 1957, the members of the Emory Diagnostic Clinic were heard. Conclusions from the last three listed meetings will be summarized by the Fulton County Liaison Committee under Cyrus W. Strickler, Jr.

It is evident that much confusion and misinformation has existed. Much emotionalism and some petty jealousy has been encountered. No simple answers are apparent as yet.

However, it is believed that continuing frank discussions will accomplish much toward better understanding between Emory University Medical School and the practicing physicians in the immediate area.

Several steps remain to be taken that will help clarify the situation:

1. Mutual agreement as to what actually constitutes the corporate practice of medicine in Georgia, from a legal standpoint.

2. Mutual agreement between the authorities at Emory and the Medical Association of Georgia as to what constitutes the highest ethical practice policies.

3. Accurate information regarding appointments, changes in policy, relevant news, etc., should be applied frequently by Emory to all interested physicians, especially those in the volunteer faculty group. This might help quell the "what's going on at Emory?" type of information.

4. Grievances, imagined or real, of practicing physicians should be presented to the dean of the medical school for appropriate action.

All parties concerned are unanimous in their desire to help Emory become as fine a medical school as possible, to insure the best possible patient care at Grady, and to raise the standards of private practice to the highest possible level. With this unanimity of purpose, surely men of good will can accomplish much.

(Since this report was filed, legal accord has been reached on the Emory Clinic problem.)

Reference Committee recommendation—Reference Committee No. 4 recommends that Addendum No. 2, to the report of the Medical Education Committee, be accepted as information.

House of Delegates Action—Accepted Addendum No. 2, to the report of the Medical Education Committee, as recommended by the reference committee on motion duly made and seconded.

ADDENDUM NO. 3—MEDICAL EDUCATION COMMITTEE

CHARLES F. STONE, JR., M.D.

WHEREAS, the Emory Liaison Subcommittee of the Committee on Medical Education, composed of Charles F. Stone, Jr., Chairman, J. Elliott Scarborough and H. B. Cason, and the following ex-officio members, Hal M. Davison, Arthur P. Richardson, and David Henry Poer, working with Messrs. Alston, Sibley, Miller, Spann and Shackelford, Special Counsel to the Medical Association of Georgia to advise on the corporate practice of medicine, have carried on extensive negotiations with the representatives of Emory University and Emory University Clinic during the past six months, and

WHEREAS, the Association's Special Counsel reports that an agreement has been reached satisfactory to Emory University and to Emory University Clinic during the past six months, and

WHEREAS, the said agreement embodies the following terms and arrangements:

(a) The University and the Clinic will take care in the future that publicity will not issue from the University which refers in any way to "Emory University Clinic," except as would be appropriate in announcing organizational changes or other facts in formal university publications;

(b) The University and Clinic will remove written provisions in the agreement between them which, in the past, might have given the impression that the University did or could control the private practice of the members of the Clinic;

(c) The University and the Clinic will limit payments from the Clinic to the University for facilities furnished to a fair and reasonable charge. The University will not have a direct interest in the earnings of the Clinic;

THEREFORE BE IT RESOLVED that the Medical Association of Georgia approve the said agreement as conforming to legal and ethical principles and endorse the Clinic arrangement at Emory University after the implementation of said agreement as an example of one way to further the best interests of medical education and the practice of medicine.

BE IT FURTHER RESOLVED that the Committee on Medical Education work with Emory University and Emory University Clinic in the implementation of the new agreements and arrangements to the end that there may continue among the Medical Association of Georgia, Emory University, and Emory University Clinic a close, constructive cooperation.

BE IT FURTHER RESOLVED that the Secretary of the Medical Association of Georgia be, and he is hereby, directed to send copies of this resolution to Emory University and Emory University Clinic as a formal expression of appreciation by the Medical Association of Georgia for the cooperation of the University and of the Clinic in helping to resolve any differences or misunderstandings which might have existed between the Medical Association of Georgia and Emory University and Emory University Clinic.

Reference Committee Recommendation—Reference Committee No. 4 recommends that Addendum No. 8, to the Medical Education Committee report, be approved with the exception of the paragraph beginning "Therefore be it resolved," and the committee recommends that the House adopt the following paragraph instead: "Therefore be it resolved, that the Medical Association of Georgia approve the said agreement as conforming to legal and ethical principles." The remainder of this paragraph is disapproved.

The eighth paragraph is approved and the ninth and last paragraph is disapproved.

House of Delegates Action—Accepted the Addendum No. 8, to the Medical Education Committee report, as recommended and altered by the reference committee on motion duly made and seconded. Addendum No. 8 as altered and approved by the House of Delegates is given as follows:

WHEREAS, the Emory Liaison Subcommittee of the Committee on Medical Education, composed of Charles F. Stone, Jr., Chairman, J. Elliott Scarborough, and H. B. Cason, and the following ex-officio members, Hal M. Davison, Arthur P. Richardson, and David Henry Poer, working with Messrs. Alston, Sibley, Miller, Spann and

Shackelford, Special Counsel to the Medical Association of Georgia to advise on the corporate practice of medicine, have carried on extensive negotiations with the representatives of Emory University and Emory University Clinic during the past six months, and

WHEREAS, the Association's Special Counsel reports that an agreement has been reached satisfactory to Emory University and to Emory University Clinic during the past six months, and

WHEREAS, the said agreement embodies the following terms and arrangements:

(a) The University and the Clinic will take care in the future that publicity will not issue from the University which refers in any way to "Emory University Clinic," except as would be appropriate in announcing organizational changes or other facts in formal University publications;

(b) The University and Clinic will remove written provisions in the agreement between them which, in the past, might have given the impression that the University did or could control the private practice of the members of the Clinic;

(c) The University and the Clinic will limit payments from the Clinic to the University for facilities furnished to a fair and reasonable charge. The University will not have a direct interest in the earnings of the Clinic;

THEREFORE BE IT RESOLVED that the Medical Association of Georgia approve the said agreement, as conforming to legal and ethical principles.

BE IT FURTHER RESOLVED that the Committee on Medical Education work with Emory University and Emory University Clinic in the implementation of the new agreements and arrangements to the end that there may continue among the Medical Association of Georgia, Emory University, and the Emory University Clinic, a close cooperation.

Abner Wellborn Calhoun Lectureship

GLENNVILLE GIDDINGS, M.D., Atlanta, *Chairman*

I wish to advise that Chester Keefer of Boston, Massachusetts, will deliver the Calhoun Lecture at the meeting of the Medical Association of Georgia in Savannah, in April. Dr. Keefer is a graduate of Johns Hopkins University, Department of Medicine. He is a member of the Association of American Physicians, the Society for Clinical Investigation and the Clinical and Climatological Association. He is also Director and Wade Professor of Medicine at the Boston University, Department of Medicine.

For some two years, he acted in liaison capacity between the American Medical Association and the Department of Health, Education and Welfare of the United States of America.

The title of his address will be "Thrombosis and Thrombophlebitis."

Reference Committee Recommendation—Reference Committee No. 4 approves this report and commends the committee.

House of Delegates Action—Adopted the report of the Abner Wellborn Calhoun Lectureship Committee as recommended by the reference committee on motion duly made and seconded.

ADDENDUM NO. 5—CRIPPLED CHILDREN'S COMMITTEE

JACK C. HUGHSTON, M.D.

The past year has seen the continued advancement of care for the handicapped child, in the State of Georgia, and those physicians more directly associated with this care feel that our state is most outstanding, by comparison, in the quantity and quality of services rendered to the handicapped children.

As you all know, it would be impossible to name each of the fine civic organizations, clubs, and related groups, who contribute so greatly to the support and care of the various programs directed to the care of the handicapped children. Their care is a tremendous job, and one which cannot be carried out by physicians

and nurses alone in any manner; and without the great services rendered by these fine groups of voluntary workers the care would be impossible.

The major direct sources of care which are most widely known to everyone constitute the services rendered by the Crippled Children's Division of the Public Health Department, with Guy V. Rice being the director of this section; the Scottish Rite Hospital in Decatur, with J. Hiram Kite being the surgeon-in-chief; the Aidmore Convalescent Hospital at Emory University, Georgia; and this past year the furthering of the cooperative efforts of these, and the tremendous number of organizations and groups, were aided by the steering of the care to the handicapped children by the meeting with Mrs. duPont and Dr. Shands, in representing the duPont de Nemours Foundation with Mrs. Schaefer, and Mr. Edward Bridges doing such an outstanding job in putting the meeting on in the capacity of officers of the Georgia Better Health Council.

The Georgia Chapter of the National Association of Crippled Children and Adults, Inc., spearheaded by their secretary, Miss Mary Webb, has continued to work toward the development of some direct services in the form of regional rehabilitation centers, and in helping to establish these. They have also aided greatly in their scholarships for the training of persons for the technical positions, so greatly needed in this state, for the filling of these various vacancies in these centers.

We all look forward to another year of advancement, and thank each of you for your contributory efforts which have made the past progress possible.

Reference Committee Recommendation—Addendum No. 5, to the Crippled Children's Committee, is approved and the committee commended.

House of Delegates Action—Adopted Addendum No. 5, to the Crippled Children's Committee report, as recommended by the reference committee on motion duly made and seconded.

ADDENDUM NO. 1—REPORT OF SPECIAL COUNSEL ON CORPORATE PRACTICE OF MEDICINE

REPORT OF WORK DONE BY ALSTON, SIBLEY, MILLER, SPANN & SHACKELFORD AS SPECIAL COUNSEL TO THE MEDICAL ASSOCIATION OF GEORGIA TO ADVISE ON THE CORPORATE PRACTICE OF MEDICINE.

The work of the firm has fallen into three areas which will be more fully described in the following report:

(1) Legal research and advice to the Council and to special committees of the Medical Association of Georgia (referred to subsequently as "Association");

(2) Advice to the Association and the Richmond County Medical Society concerning that society's relations with the Medical College of Georgia and the Eugene Talmadge Memorial Hospital;

(3) Negotiations with Emory University, Emory University Clinic, and their attorneys.

(1) *Legal research and advice to the Council and to special committees of the Medical Association of Georgia.* When first advised that the Association considered retaining the firm to advise on questions concerning the corporate practice of medicine in Georgia, the firm made a study of the laws of Georgia and of other jurisdictions on that subject. A memorandum, discussing whether corporate practice is forbidden in

Georgia and what constitutes the corporate practice of medicine, was submitted to the Council of the Association at its meeting in Savannah on September 15 and 16, 1956.

The firm next carried on a full study of all available materials on the practices of hospitals in hiring and providing the services of anesthesiologists, radiologists, and pathologists. This entailed a study of the opinions of attorneys general in 25 states. It also entailed a study of the many cases in various states on the subject of corporate practice of a profession for analogy to the medical practice. A letter of conclusions was submitted to the Council of the Association at its special meeting on October 28, 1956. This letter covered the legal aspects of the corporate practice of medicine, with special reference to the particular fields of anesthesiology, radiology, and pathology. In addition, it made reference to the particular statutory position of the Eugene Talmadge Memorial Hospital at Augusta. This letter was ordered distributed for information to the component county medical societies by the Council of the Association at the meeting on October 28th.

On the request of the Association, the firm submitted for the consideration of the Council of the Association, a draft of a letter construing the Principles of Ethics of the American Medical Association, adopted by the Medical Association of Georgia, as they apply to the corporate practice of medicine. This draft was approved by the Council of the Association at the meeting on October 28th for transmission to the president and secretary of the Richmond County Medical Society and to the component county medical societies throughout the state.

In February, Dr. Davison and the Council Special Committee on Medical School Ethics asked for advice on a proposed draft of relations between medical societies and medical schools. Advice was given, and Mr. Shackelford attended the meeting of the committee at which the proposed draft was ordered mimeographed and sent to all special committee members for their approval, further study, and suggestions. The final draft was approved by the Council of the Association at its Albany meeting March 9 and 10, 1957.

During the ensuing conferences with particular schools and hospitals the firm has continued its research on the various questions and kept up with current materials and memoranda from court decisions and other sources.

(2) *Advice to the Association and the Richmond County Medical Society concerning that society's relations with the Medical College of Georgia and the Eugene Talmadge Memorial Hospital.* The Richmond County Medical Society for several months had tabled applications for membership in the society submitted by physicians affiliated with the Medical College of Georgia at Augusta. On September 25, 1956, Mr. Shackelford, at the request of the Association, attended a meeting of the Richmond County Medical Society at Augusta, advising the society on the problems presented by the Medical College of Georgia and the Talmadge Hospital and the statute authorizing it to accept "pay patients." Pursuant to Mr. Shackelford's advice, the society tabled the applications of doctors affiliated with the Medical College and Talmadge Hospital for admission to the society until the relations between the society and the college and hospital should be clarified.

On October 28, 1956, Mr. Shackelford and Mr. Spann attended a special meeting of the Council of the Association concerning the relations of the Richmond County Medical Society and the Medical College of Georgia. Advice was given the Council on how an agreement between the society and the college could be drawn to meet legal and ethical objections and yet to provide for practical administration of the college and hospital.

During December 1956, after a request by the Association, this firm gave further advice on the relations between the Richmond County Medical Society and the college.

On January 22, 1957, at the request of the Richmond County Medical Society, at the direction of the Executive Committee of Council of the Association, and with advance notice to Dr. Pund, President of the Medical College of Georgia, so that counsel for the college might be present, Mr. Shackelford went to Augusta for a meeting of the county society at which members under contract with the college were present. At that meeting the "Waters Resolution," embodying an arrangement for ethical relations between the society and the college, was passed by a vote of 85 to 23.

The "Waters Resolution" provided:

"(a) That public relations between hospital and college shall be cleared through a committee of the county medical society and shall conform with the code of ethics of the American Medical Association.

"(b) That a liaison committee shall be appointed consisting of five members from the Richmond County Medical Society, two from the Council of the Association, the President of the Medical College of Georgia and the Director of the Talmadge Hospital. This committee is to review complaints and to give reports to the Richmond County Medical Society.

"(c) That the policy of admissions of patients at the college and hospital shall be carried out to the end that the medically indigent shall be cared for, that patients of unusual teaching interest shall be provided, and that pay patients shall not be accepted except under dire emergencies and unusual circumstances.

"(d) Patients, if able to pay, admitted to the hospital in dire emergencies and unusual circumstances, shall be billed for hospital charges but not for professional services. Such patients may be invited to make a voluntary contribution to the research fund of the Medical College in lieu of payments for professional services."

On January 27, 1957, Mr. Shackelford attended the meeting of the Council of the Association in Macon. At that meeting the "Waters Resolution" was considered, and the Council resolved that it was compatible with the ethics of the Association and that it demonstrates one way for local societies and medical schools to cooperate for legal and ethical relations. The committee which drafted the "Waters Resolution" has recommended that it be amended to add the following paragraph to the section entitled "fees":

"However, the question of professional fees shall be settled finally in regard to legal matters by at-

torneys representing the Medical Association of Georgia and the Board of Regents; and the question of medical ethics shall be settled by the Council of the Medical Association of Georgia."

Whether the authorities of the Medical College of Georgia and the Talmadge Memorial Hospital will accept the principles embodied in the "Waters Resolution" remains to be seen. Further advice and negotiations will be necessary if they do not do so.

(3) *Negotiations with Emory University, Emory University Clinic, and their attorneys.* Negotiations commenced with a formal meeting on November 29, 1956, attended by Mr. Shackelford and Mr. Spann, Dr. Hal Davison, Dr. Henry Poer and Dr. Charles S. Stone, representatives of the Association, Dr. Elliott Scarborough and Dr. Arthur Richardson and other representatives of Emory University and Emory University Clinic. At this meeting the differences were delineated and all parties agreed to work together to remove them. The clinic and university representatives assured the representatives of the Association that they wished to go as far as possible in satisfying objections raised as to legal or ethical aspects of the Clinic-University relationship without regard to whether or not they recognized such objections as being valid.

During December two meetings were held at which the lawyers for the three parties met for full discussion and exchange of information. Further meetings were held on February 7 and 11, 1957. At the latter two meetings, five proposals were discussed as a basis for settling the differences. The university presented a proposed statement of its policy as to releases of publicity concerning the clinic. This statement proved entirely satisfactory to the representatives of all parties. On other points understanding was reached on principle, but factual differences remained to be discussed further.

On April 3, 1957, after two months of correspondence and telephone conferences from which the facts were further ascertained, another conference of the lawyers was held. At that meeting it was discovered that the factual differences were clarified to the point that concrete proposals looking to a final settlement could be agreed upon.

The proposed settlement embodies the following agreements and arrangements:

(a) The university and the clinic will take care in the future that publicity will not issue from the university which refers in any way to "Emory University Clinic," except as would be appropriate in announcing organizational changes or other facts in formal university publications.

(b) The university and clinic will remove written provisions in the agreement between them which, in the past, might have given the impression that the university did or could control the private practice of the members of the clinic.

(c) The university and the clinic will limit payments from the clinic to the university for facilities furnished to a fair and reasonable charge. The university thus will not, in the future, be subject to the criticism that it has a direct interest in the earnings of the clinic.

This firm believes that this settlement means that Emory definitely will not be engaged in the corporate practice of medicine. It provides the basis for close, constructive cooperation in the future by Emory, the

clinic, and the Association, and justifies an endorsement by the Association of the clinic plan as conforming to legal and ethical principles.

CONFERENCES AND MEETINGS ATTENDED BY MEMBERS OF THE FIRM OF ALSTON, SIBLEY, MILLER, SPANN AND SHACKELFORD:

7/10/56; Atlanta; Legal Council Committee, MAG; Shackelford, Spann; Corporate Practice Memo Presented.

9/25-26/56; Augusta; Richmond Medical Society; Shackelford; Talmadge Hospital.

10/28/56; Atlanta; Special MAG Council Committee; Shackelford, Spann; Richmond County Relations.

11/29/56; Atlanta; MAG, Emory and Emory Clinic Representatives; Shackelford, Spann; Corporate Practice at Emory.

12/26/56; Atlanta; Lawyers of MAG, Emory and Clinic; Shackelford, Spann, Moore; Corporate Practice at Emory University Clinic.

1/22/57; Atlanta; Lawyer for Emory; Spann; Corporate Practice at Emory.

1/22/57; Augusta; Richmond Medical Society; Shackelford; Talmadge Hospital.

1/27/57; Macon; Council of MAG; Shackelford; Talmadge Hospital.

1/31/57; Atlanta; Lawyer for Emory; Spann; Corporate Practice at Emory.

2/7/57; Atlanta; Lawyers of MAG, Emory and Clinic; Spann, Moore, Shackelford; Corporate Practice at Emory University Clinic.

2/11/57; Atlanta; Lawyers of MAG, Emory and Clinic; Shackelford, Spann, Moore; Corporate Practice at Emory University Clinic.

2/17/57; Atlanta; Special Committee on Medical School Relations of Council of MAG; Shackelford; Draft of Statement for Relations Between Medical Societies and Schools.

4/3/57; Atlanta; Lawyers of MAG, Emory, and Clinic; Shackelford, Spann, Moore; Corporate Practice at Emory University Clinic.

Reference Committee Recommendation—Addendum No. 1, to the Council Report, is accepted for information.

House of Delegates Action—Adopted Addendum No. 1, to the Council Report, as recommended by the reference committee on motion duly made and seconded.

Resolution No. 11 M.D.—Social Security

E. C. McMILLAN, M.D., Macon

WHEREAS, the Bibb County Medical Society has voted overwhelmingly in favor of inclusion of the medical profession under compulsory social security coverage, and

WHEREAS, the medical profession is one of the few professions still not included in the social security program, and

WHEREAS, the Insurance Committee of the Medical Association of Georgia has adopted a similar resolution, and

WHEREAS, the Congress will not vote to include any professional group under social security except upon request of the majority of that group, and

WHEREAS, the insurance coverage under social security is cheaper than that offered by any commercial

insurance carrier, the undersigned Bibb County Delegate submits the following resolution to the House of Delegates of the Medical Association of Georgia, to wit:

BE IT RESOLVED that the House of Delegates of the Medical Association of Georgia approve the inclusion of the medical profession under the social security program and that copies of this resolution be forwarded to the AMA and to the Georgia Congressional delegation.

(Resolution No. 11 and Resolution No. 18 below, were acted on jointly.)

Resolution No. 18
Social Security

LUTHER H. WOLFF, M.D., Columbus

WHEREAS, the federal government has shown an increasing tendency to control and regulate the lives of the citizens of the United States by various security schemes, and

WHEREAS, the compulsory social security program, with its ever increasing and widening influence, is one further step toward such control, and

WHEREAS, serious studies and evaluation of the proposed social security program for physicians, as published in the *Journal of the American Medical Association*, has shown that this proposed program is disadvantageous to physicians, not only from the aspects mentioned above, but also from a financial viewpoint,

THEREFORE BE IT RESOLVED that the Medical Association of Georgia use all its influence and resources to combat compulsory social security for physicians, and

BE IT FURTHER RESOLVED that the Association support actively in every way possible the passage of the Jenkins-Keogh Bill.

Reference Committee Recommendation—A joint meeting of Reference Committees No. 1 and No. 4 was held at 9 a.m., April 30, 1957, for consideration of Resolutions No. 11 and No. 18 and paragraph No. 3 of the report of the Fifth District Vice-Councilor. Since all these reports covered the same subject but with some difference in views, they were considered together.

Reference Committee No. 4 recommends that the portion of these resolutions which concerns social security coverage for doctors be deferred for action by poll of the entire membership of the Medical Association of Georgia as outlined in the joint decision.

The joint decision of Reference Committees No. 1 and No. 4 is that the secretary of each county medical society shall be instructed to poll the active dues-paying members of the society and send the results to the state office as to number for and number against social security coverage for doctors by November 1, 1957. Cards with members' names are to be furnished to the secretary of each county society by the state office; such cards to be signed by each member voting. The cards are to be furnished to Council and tabulated by a tellers committee of Council. Council is requested to act on this matter through proper channels in accordance with the will of the majority of the ballots. The secretary of each county society is to be responsible for contacting each member and returning the cards to the executive secretary.

The cards shall have a statement that: "Since doctors cannot be covered on a voluntary basis by social security, do you favor coverage of doctors by compulsory social security? Yes..... No....."

Resolution No. 18, paragraph 6—Reference Committee No. 4 recommends that the paragraph which reads that the Association support actively, in every way possible, the passage of the Jenkins-Keogh Bill be approved by the House of Delegates.

House of Delegates Action—Adopted the report of the reference committee concerning Resolutions No. 11 and No. 18 on motion duly made and seconded.

Don F. Cathcart, Atlanta, made the following motion which was duly seconded and approved: "Since all of our constituents did not have the privilege of hearing Mr. James W. Murray and Mr. C. Joseph Stetler on the subject of social security, I propose a resolution to the effect that a complete report of the remarks of these gentlemen be sent to each member of the MAG along with the cards proposed for voting purposes."

The chairman of Reference Committee No. 4 then moved that the report be adopted as a whole with the changes noted, and this motion was duly seconded and approved.

Report of Reference Committee
No. 5

H. G. Davis, Jr., Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 5 met at 2:00 p.m., April 29, 1957, in Room 240, Hotel DeSoto, Savannah. Members present were: H. G. Davis, Jr., Sylvester, Chairman; C. J. Roper, Jasper, Vice-Chairman; H. E. Weems, Perry, Secretary; A. M. Phillips, Macon; C. Roy Williams, Wadley; Roy L. Gibson, Columbus; George W. Wright, Augusta.

First District Councilor

LEE HOWARD, SR., M.D., Savannah

Your Councilor has attended every regular meeting of Council during the year and all except one of the several special meetings, and also met with three special committees.

The Southeast Georgia Society remains as the only progress in consolidating small societies in the district into larger groups. As of December 31st, 1956, there were 208 members in the First District, a gain of four over December 31, 1955. The chief gain was in the Georgia Medical Society of Chatham County; seven members. The Bulloch-Candler-Evans group lost two members; Burke County, one member; and the Southeast Georgia Society, one member. Emanuel County gained one member.

The above figures show the progressive trend in the physician depletion and shortage in our rural communities.

It is still felt that there is one society, Liberty-Long-McIntosh, that should be dropped and that the Emanuel, Jenkins and Screven Societies are too small to be active societies. The Screven and Jenkins societies should be consolidated and the Emanuel County Society members should join some nearby larger group.

I am sorry not to be able to report on society activities throughout the district for the year as I have only attended meetings of Emanuel County and the Georgia Medical Society. The Georgia Medical Society attendance was very poor during the past year. Some improvement has been noted recently.

For reasons that are hard to explain, but most likely

due to a misunderstanding, there was no meeting of the First District Society in 1956 in spite of the fact that the May 18, 1955, meeting was well attended and publicized. Notices have just been received for the annual meeting to be held April 17, 1957, in Statesboro.

In concluding my long term as Councilor for the First District, beginning so far back that the MAG records have never been able to give a date, I regret having given such a spotty, inadequate service for a good part of the time but I have thoroughly enjoyed my work with Council during the past several years. I am certain that the good fellowship enjoyed and friendships made have more than compensated for the time and effort spent during the last two trying years.

Reference Committee Recommendation—The report of the First District Councilor was accepted and approved with the addition of the request to Council to study the recommendation concerning the dissolution of small societies and the suggestion that officers of the First District function more actively and hold district society meetings at least once during each year.

House of Delegates Action—Accepted the report of the First District Councilor and adopted the recommendation of the reference committee on motion duly made and seconded.

First District Vice-Councilor

CHARLES T. BROWN, M.D., Guyton

The MAG legislative conference sponsored by Dr. Albert M. Deal of Statesboro and held January 10, 1957, at 7:30 p.m. at Statesboro Country Club was a very enjoyable occasion. Physicians together with members of the Senate and House of Representatives from the various sections of the First District were present and were introduced to each other. Mutual problems and proposed legislation pertaining to the medical profession were discussed from the standpoints of the laymen and physicians. This meeting, we feel, was a very important one as it will create a better understanding and more friendly relationship between our law makers and ourselves. We hope that it will be an annual event and will cover every district in the State.

Reference Committee Recommendation—The report of the First District Vice-Councilor was accepted and approved.

House of Delegates Action—Adopted the report of the First District Vice-Councilor as recommended by the reference committee on motion duly made and seconded.

Second District Councilor

GEORGE R. DILLINGER, M.D., Thomasville

The local societies in the Second District have all been active during the past year. The larger societies, such as Dougherty County and Thomas-Brooks have had regular meetings with outstanding scientific programs.

The combination of the Thomas County Medical Society and Brooks County Medical Society has worked well and has increased interest and attendance.

During the legislative activity of the 1957 session, the members of the local societies in the district cooperated in a most excellent manner and are to be congratulated on their activities and interest in legislative activities of the Association.

In general, medical organizations in the Second District are now more active than they have ever been. The district society is functioning well and having outstanding programs. We believe too, that the increased activity of the Headquarters Office of the MAG is in a great measure responsible for the increased interest in the activities shown.

Reference Committee Recommendation—The report of the Second District Councilor was accepted and approved.

House of Delegates Action—Adopted the report of the Second District Councilor as recommended by the reference committee on motion duly made and seconded.

Third District Councilor

W. G. ELLIOTT, M.D., Cuthbert

The number of physicians in the Third District has increased a little in the past year. There are 196 in this district. There has been an increase of nine in Muscogee County membership, and a decrease in some of the smaller counties. The overall increase being 10 in the District.

I have been unable to visit many of the county societies because of the uncertainty of the meetings and not being notified about the meetings. Some of the counties meet very seldom.

I understand the Flint and Peach Societies are very active and meet monthly except during the summer months.

The Sumter County Medical Society meets monthly except during the summer. The Randolph-Terrell Society was recently re-organized and plans to meet monthly alternating between Cuthbert, Dawson, and Richland.

The Muscogee society is a very good one, and is very active. They have very good programs every month. They also continue to publish a very good monthly bulletin.

I have very little information about the other societies in the district. I would like to visit all of the societies at some time during the year, but I am unable to do so, if they do not let me know the date of their meeting.

Two district meetings are held each year in April and November. The last meeting was held in Cuthbert, and was fairly well attended, and we had a good program. We were visited by the president of the Medical Association of Georgia, and the president-elect. Another meeting is scheduled to be held in April at Lake Blackshear.

Third District Membership: Ben Hill-Irwin-11; Flint-17; Peach Belt-12; Muscogee-106; Ocmulgee-14; Randolph-Terrell-13; Sumter-17; Taylor-5; Wilcox-1.

Reference Committee Recommendation—The report of the Third District Councilor is accepted and approved with the request to Council to study the recommendation as to small societies in that district.

House of Delegates Action—Adopted the report of the Third District Councilor as recommended by the reference committee on motion duly made and seconded.

Third District Vice-Councilor

LUTHER H. WOLFF, M.D., Columbus

Attended Council meetings at St. Simons Island, Atlanta and Savannah.

With the help of local county medical society officers, urged the passage of MAG sponsored legislation to our local legislators.

Reference Committee Recommendation—The report of the Third District Vice-Councilor accepted and approved.

House of Delegates Action—Adopted the report of the Third District Vice-Councilor as recommended by the reference committee on motion duly made and seconded.

Medical Defense Committee

W. LOOMIS POMEROY, M.D., Waycross, *Chairman*

As in the past, it would seem that the physicians of Georgia are still being faced with many actual and threatened suits for malpractice. During the year 1956 and 1957 up-to-date, the Association's Attorney, Mr. John A. Dunaway, has been notified or participated in, (1) 23 cases brought over from last year. Of these, seven have been closed, (2) 22 cases remain pending at this time, and (3) six new cases have appeared since the date of the last report of this committee. This does not include a number of threatened or possible pending suits. Although last year's figures were not available at the time of this report, it would seem that the number of suits brought this year is about average for the past several years, which is a definite increase over the figures of five years ago.

As usual, more suits still continue to be filed in the greater Atlanta area than for the rest of the state combined. This may signify only that almost one-half of the state physicians are located in this area, but could also indicate a greater tendency on the part of the urban population, encouraged by members of the legal profession, to take action of this kind. It could also indicate failure of the busy city specialist to get to know and fully acquaint his patients with untoward results and situations at the time of occurrence. Being truthful with our patients, in the long run, is certainly the only right approach. Again, it would seem that many suits are brought about by a careless word or inference inadvertently dropped by a brother physician. No matter how skilled any of us are, we are always vulnerable.

It is noted with interest and satisfaction that between 1300 and 1400 members of the Association now participate in the Association's program of professional liability. Although about 10 threatened claims have been rumored, only four or five actual suits have been brought. In each case a committee from the county medical society met with the physician and adjudicated the matter, usually resulting in the suit being dropped. There is one case of settlement out of the court on the advice of the county medical society. This certainly, at least in part, is the answer to many suits.

No specific recommendations, other than those in general mentioned in the body of the report, appear necessary at this time. A detailed report (for Association records only) as furnished by Mr. John Dunaway, Attorney for the Medical Association of Georgia, is attached.

Reference Committee Recommendation—Medical Defense Committee report accepted and approved.

House of Delegates Action—Adopted the report of the Medical Defense Committee as recommended by the reference committee on motion duly made and seconded.

Rural Health Committee

J. L. WALKER, M.D., Clarkesville, *Chairman*

The Rural Health Committee held its first meeting in June of 1956 under the leadership of George Alexander, Forsyth. Certain projects were discussed at this time, and a tentative program was devised to be carried out during the year by the committee. One of the primary projects that was discussed at this time was the recruitment of paramedical personnel. Henry A. Bridges,

Bainbridge, Georgia, was appointed on a special subcommittee to study this subject. Shortly after this meeting, Dr. Alexander suffered a coronary heart attack and was unable to carry the work of the committee any further. J. L. Walker, Clarkesville, Georgia, was appointed chairman of the committee at this time, succeeding Dr. Alexander.

Dr. Walker attended the meeting sponsored by the Council on Rural Health of the American Medical Association for Chairman of State Rural Health Committees, which was held at Purdue University on October 19-20, 1956. This was a very enlightening meeting and served as an eye opener for the chairman. Up to this time, the full realization of what opportunities were offered to the Rural Health Committee had not been in my mind. There was considerable enthusiasm at this meeting, and I was particularly impressed to find out the number and extent of the projects that were being carried on by the various rural health committees of the states throughout this country. Mr. Aubrey Gates, who is the able Director of the Council on Rural Health of the American Medical Association, was present at this meeting, and also F. S. Crockett, who is chairman of the same council, was present. Mr. Aubrey Gates was the first speaker of the program, and he emphasized the subject of the organization with which we work. He stated that we should become acquainted with all organizations in our state which are concerned with rural programs of any sort because these were the people that we would be working with. He emphasized to us that if we made ourselves available, they would call on us to help them in their program, and in turn, we would be able to develop a better program for rural health if we know what the people who come from the rural areas think of the initial problems. Discussions were had of how to get cooperation of the people in the county and local communities on projects and also how to get cooperation and help from the doctors themselves in these programs. One of the main things that was brought out in this conference was the need for a state advisory committee to the Rural Health Committee. It was suggested that this state advisory committee should include people from the extension service, 4-H Club, State Home Demonstration Clubs; State Ministerial Associations; and Farm Bureau. A number of the states which have organized such advisory committees state that they have been very helpful and they are used only in an advisory capacity and not as an actual working part of the Rural Health Committee.

Following this meeting, Mr. Aubrey Gates was invited to come to Georgia for a conference. He visited us in February. The conference was held between Mr. Milton Krueger, Executive Secretary of the Medical Association of Georgia; Dr. Walker, and Mr. Gates. Considerable discussion was had as to how we should organize our program here in Georgia. It was definitely decided that we should have an advisory committee and that we should, in the beginning, limit our projects to some extent, and try to concentrate and do a good job on a few projects, and then later on expand.

Following the session with Mr. Gates, Miss Lucile Higginbotham, from the State Extension Service, had been invited to discuss the possible organization of an advisory committee. Miss Higginbotham was very enthusiastic about the organization of such an advisory committee, and she agreed to recruit the personnel from

the extension service and the 4-H clubs and Home Demonstration Council to serve on this advisory committee. Following this, Chairman Walker had a conference with the State Director of Vocational Education, Mr. Hicks. At that time a discussion was had as to the possibility of setting up more training classes under the department for practical nurses and for the training of laboratory aides. Further discussion on this subject will be presented in the report of the Rural Health Committee meeting.

The Rural Health Committee met on March 3, 1957, at the Academy of Medicine in Atlanta. Committee members present included: J. L. Walker, Clarkesville, chairman; Charles T. Brown, Guyton; M. F. Arnold, Hawkinsville; T. A. Sappington, Thomaston; John P. Heard, Decatur; H. C. Derrick, Lafayette; H. B. Cason, Warrenton. Also present was Mr. Milton Krueger, Atlanta, MAG executive secretary. After a review of the work that had been done up to this time, a general discussion was had of the following items.

1. *Preceptorships*—Maurice H. Arnold reported that the Georgia Academy of General Practice has a committee on preceptorships which has been in contact with both of the medical schools in the state, and that some progress had been made on this subject. That this committee would be meeting with both the medical schools sometime during the month of March, and Dr. Arnold was appointed as liaison between the Rural Health Committee and this committee here, and was instructed to report to the GAGP Committee that any help that could be given by the Rural Health Committee would be forthcoming.

2. *General practice lectures at the two medical schools in Georgia*. Some discussion has been had with the deans of both the schools, and they seem to be amenable at this time to having some type of lectures at both medical colleges. We are, at the present time, obtaining information from other schools, notably the three medical schools in Ohio and the University of Louisville; at each of these places a number of lectures are given in the senior year by general practitioners of the area, on various problems of going into medical practice. There may be further reports on this in an addendum if more information is available.

3. *The family physician*. It was pointed out in the discussion that, particularly in some of the larger counties of the state, sometime when people called in for a doctor, information was not generally available; and at times people call in and say that they want a special kind of doctor only to find that that was not at all what they needed. It was decided to write to all of the county medical societies in the state and recommend to them that any and all occasions when they had requests for doctors they were to suggest first to the people that they seek advice from their family physician and if none were available or if they had no family physician then to give them the name of the general practitioners in the area or those who did general practice so that they might seek his counsel.

All of those present agreed that paramedical recruitment is one of the most urgent needs that we had in this state. The Department of Vocational Education stated that the school which they had for practical nurses at the South Georgia Trade School in Americus was functioning but that there was a lack of applica-

tions at this school, and they requested that we do everything that we could to aid in getting more applications for this school so that they would not only carry a full complement of personnel for training, but also that they might be more selective in picking the personnel for training there. Also the Director of the Department of Vocational Education of the State said that they were ready and were proceeding to organize another school for practical nurses which will be located at the North Georgia Trade and Vocational School in Clarkesville. Also, he stated that they had funds available and were ready to help us set up a school for the training of laboratory aides. It was felt by all of the members present that laboratory aides are certainly necessary, particularly in the rural areas of the state. There just aren't enough available registered technicians to supply the hospitals and doctors throughout the state. It was felt by most of the group present that a program of training for laboratory aides which lasted approximately 12 months could train an adequate number of personnel and also could train them in the procedures that needed to be done in the doctor's office and the smaller hospitals. If well trained personnel such as this were available in the hospital, then the more complicated procedures could be sent to the larger laboratories in the state where trained medical technicians were available and perform these tasks.

The committee has been tentatively organized which is to meet at the state medical society meeting in April in Savannah to discuss how such a school might be set up. The committee is to be composed of Lester Forbes, pathologist, Atlanta; Walter Sheppard, Augusta; John T. Godwin, Atlanta; Darrell Ayer, Atlanta; and Lee Howard, Sr., Savannah. We would like to ask for the support of the doctors throughout the state in both these projects. And for them to let their hospitals and patients and other people in their area know about the training program for practical nurses and try to get more applicants for these schools so that we can have better grade practical nurses coming out from them.

John P. Heard was appointed to study and investigate the possibilities of the Rural Health Committee composing and publishing a pamphlet or booklet to be distributed to high school students which would give information regarding availability of paramedical and other related careers.

A discussion was had of the Junior-Senior Day Programs at both the Medical College of Georgia and Emory University for the year 1957. Maurice H. Arnold was appointed chairman to develop the program for the Medical College of Georgia; H. C. Derrick was appointed to handle the program to be developed for Emory University. Both the schools have been most cooperative in setting up the Junior-Senior Day, and also the Mead Johnson Company has been very cooperative in offering to pick up the check for the expenses involved in these programs.

The problem of physician placement which was handled by the Better Health Council for the past year or so was also discussed, and by general agreement it was decided that the Rural Health Committee from each district in the state would be responsible for being a subcommittee to work with Mr. John Kiser of the Headquarters Office to investigate various communities in their districts which were seeking a doctor to locate

there. Mr. Kiser is to handle the paperwork in his office, both on the communities and on physicians who are seeking places, and then he will contact the Rural Health Committee member in the district from which a community is applying, and if necessary the two would visit the community to determine the true need for a physician there and any other information that might be helpful to a physician desiring to locate in that area.

It was definitely decided at this meeting to establish an advisory committee to the Rural Health Committee and that this committee be asked to meet with the Rural Health Committee at an early date. April 3 was set for the date of this meeting, and it was to be held at the Rock Eagle State Park, which is a 4-H center near Eatonton, Georgia. It was decided that the committee would be composed of two representatives from the Farm Bureau; four representatives from the Agricultural Extension Service; and one representative of the Georgia Council of Churches. As of the date of this report, the following people have been appointed to serve on this committee: Miss Marian Fisher, Assistant 4-H Club Leader, Athens; Mr. W. A. King, District Agent of the Northwest District of Georgia, Athens; Miss Lucile Higginbotham, Health Education Specialist, Department of Extension, Athens; Dr. Herman L. Turner, Coventry Presbyterian Church, Atlanta; representatives have not yet been appointed from the Farm Bureau.

Chairman Walker attended the National Rural Health Conference which was held in Louisville, Kentucky, March 7-8-9. This conference is sponsored by the AMA Council on Rural Health. The meeting was very inspiring, and again I was able to learn a number of things about the way that Rural Health Committees are functioning in other communities. Also I had the opportunity to hear representatives of various farm organizations speak forth expressing opinions on what they felt were the primary needs in rural health. It was refreshing to note that the general attitude of most of the lay people who attended this conference regarding doctors was one of a sympathetic understanding of our problems, and they wish to be helpful to us as well as to have our help in helping them to solve the problems of Rural Health in their community.

It is felt that with the background obtained at both conferences which I have attended, and with our upcoming conference on April 3 which will be reported in an addendum, that we are on the verge of developing a rural health program for our state which we think will be helpful to both the medical profession and to the lay people. The primary purpose, of course, is to help have better health for rural communities. Many of these problems apply to the large urban communities also because in these areas so many people are now moving out into the suburbs where their problems are the same as people in rural communities. One word that was coined at the National Health Conference was the word *rurban*, in other words in many areas the problems join together, particularly around our large cities. Many states are now holding a State Rural Health Conference.

It is felt that the meeting which is to be held with the Advisory Committee will really comprise a small scale rural health conference for our state, and we expect that out of this meeting there will eventually grow

the need for a state rural health conference. However, we felt that it was best to let this grow on us and not try to jump off the deep end in a big way right in the beginning. There are many problems to be solved for our state along rural health lines, and it is felt by this committee that there is a big challenge here for us. We feel that we should meet this challenge, and we certainly think that the doctors are capable of helping to find solutions to these problems. We ask the aid of the entire medical profession in carrying out this program.

Reference Committee Recommendation—The Rural Health Committee report was accepted and approved. We desire to emphasize the very good job and vast amount of work that was accomplished by J. Lee Walker and his committee during the past year. We wish that the suggestions they offer be carried out as completely as possible.

House of Delegates Action—Adopted the report of the Rural Health Committee as recommended by the reference committee on motion duly made and seconded.

Public Service Committee

CHRIS J. McLOUGHLIN, M.D., Atlanta, *Chairman*

Briefly, during the past year, your Public Service Committee has continued many of the projects established in the previous years. It has worked mainly by encouraging county societies and districts to establish their own Public Service projects. The results have been very satisfactory. Most of the districts and many individual societies have been visited in an effort to stimulate their interest in public service and to assist wherever possible in the establishment of projects. Medical exhibits, films, AMA information booklets, press and radio releases have all played a part in augmenting public relations. Many societies continued to present medical forums during the past year with very satisfactory results. A series of forums on television originated in Atlanta with participants from many areas covered by the TV broadcasts.

An extensive plan to promote automobile and highway safety was bogged down to some extent by becoming too closely associated with inactive groups which we had counted on for considerable activity. Despite this, auto safety stickers were distributed to all members of the Medical Association of Georgia as a means of identifying an automobile as belonging to (a) a physician, (b) a member of the Medical Association of Georgia, (c) one who is interested in driving safely. One of the most promising public service projects established has been the Interprofessional Relations Council. Quite a few programs have been discussed and an auspicious start has been made. A program for a statewide vaccination of all of the population of Georgia under the age of 40 has been worked out, and statewide vaccinations should be in full swing by the time of the annual session.

Plans for the coming year include the completion of a booklet to be supplied to all the members of the Medical Association of Georgia, especially applicable for the indoctrination of new members. We will endeavor to promote newspaper releases on a weekly basis, with articles on health being supplied through the headquarters office. County medical societies' contributions to community activities are to be encouraged, and speakers for service groups, such as Kiwanis, Lions, Civitan, Rotary, etc., are to be provided. In this project, it is planned that the executive secretary and his assistants should have a very active part. A program for highway

safety has been initiated and studies are to be made in conjunction with the National Safety Council and Columbia University. The Interprofessional Relations Council will continue the good work it has begun. Coordination of work with legislative committees will continue. As frequently as possible, and when invited, visits will be made to local societies to continue stimulation of Public Service activities in those areas.

Reference Committee Recommendation—The Public Service Committee report is accepted and approved with the assumption that the vaccination mentioned, but not specified in the second paragraph, was Salk Vaccine vaccination.

House of Delegates Action—Adopted the report of the Public Service Committee as recommended by the reference committee on motion duly made and seconded.

Committee on Cancer

J. ELLIOTT SCARBOROUGH, M.D., Emory University,
Chairman

The Cancer Committee has been concerned chiefly during the year with four main subjects, namely (1) the state aid cancer control program; (2) development of the cancer registry system; (3) encouragement of cytological diagnostic methods; and (4) professional education.

A formal meeting was held on September 14, 1956, at 2:30 p.m. in the offices of the American Cancer Society at 2025 Peachtree Road, N.E. The following were present: Everett L. Bishop, Enoch Callaway, Thomas Harrold, John T. Mauldin, R. C. Pendergrass, Hoke Wammock, and Elliott Scarborough, Chairman. W. J. Murphy, John T. Godwin and A. H. Letton, and Lon Sullivan were invited and attended.

The State Aid Cancer Control Program. Although the number seeking state aid has decreased, the number requiring long hospitalization and expensive care has increased, consequently taxing the program heavily. The success of the program continues to be indebted to the hospitals who are reimbursed on the basis of only 75 per cent of cost and the doctors who give their services free to these indigent cancer patients. A plan was discussed for dividing the state into regions with a financial quota set up according to population. This will require more study.

Cancer Registry System. Tumor registries have been set up in most of the approved cancer clinics, and uniform records are being developed throughout the State. At the present time these registries are limited to the hospitals in which the clinic is located. With the assistance of the State Cancer Control Program, W. R. Vogler has visited all of the tumor registries and also met with their record librarians. When they are established, a central registry for the entire state can be considered. The Medical Association has received a communication from the American College of Surgeons outlining this program and requesting support of it.

Cytological Diagnostic Tests. Attempts are being made to determine the availability of this diagnostic test throughout the state and also to find out the possibilities of extending this service through the established pathologists. John Godwin, chairman of this committee in the American Cancer Society, Georgia Division, discussed this problem.

Professional Education. Doctors are receiving the "Cancer Bulletin" through the Cancer Control Service of the Department of Public Health and "CA" from the Georgia Division. The cancer committee of the

Medical Association of Georgia offered to cooperate with the Professional Education Committee of the American Cancer Society in supplying speakers for talks to county and district medical meetings. There are also a number of films available which could best be shown under medical supervision.

Throughout the year many informal meetings were held with W. J. Murphy of the Cancer Control Service and Mr. Lon Sullivan, Executive Director of the Georgia Division of the American Cancer Society. I would like to take this opportunity to thank them for their complete cooperation with the Cancer Committee of the Medical Association of Georgia.

Reference Committee Recommendation—The Cancer Committee report is accepted and approved.

House of Delegates Action—Adopted the report of the Cancer Committee as recommended by the reference committee on motion duly made and seconded.

Veterans' Affairs Committee

HARTWELL JOINER, M.D., Gainesville, *Chairman*

We have kept up with the national program, preferably involving legislation and administration of medical services to veterans and to their families. The past year the AMA had a series of regional meetings, calling in the committeeman from each state in certain regions. These meetings were held in Chicago at the office of the AMA. The chairman has been in conference with Dr. Orr, the AMA chairman, on one occasion during the past year. The activities have been fairly quiet for the past two years, and it seems that in the near future, the AMA's program will be considerably more vigorous.

The main problem this year has been one of a new contract for medical services to veterans at doctors' offices. It is universal opinion that the fees for these services now are too low and it is recommended through a separate letter that professional services to all types of veterans be increased by 33 1/3 per cent over the previous contract level. This is not out of proportion with the other expenses and cost.

There is now a cooperation between the physicians and VA of the state, and we are approaching a more equitable solution to our problems on our national level once again. A word of warning: being patient, tolerant, and not too critical for a long period of time will accomplish the aims of the physicians of this country.

Reference Committee Recommendation—Veterans Affairs Committee report is accepted and heartily approved.

House of Delegates Action—Adopted the Veterans Affairs Committee report as recommended by the reference committee on motion duly made and seconded.

Scientific Exhibit Awards

TED F. LEIGH, M.D., Emory University, *Chairman*

The principal functions of the Scientific Exhibits and Awards Committee is to present the scientific exhibit awards at the annual meeting, to select a secret committee for the awards, and to present the awards. The annual meeting in Atlanta in 1956 had the best scientific exhibits' section in the history of the society. We shall endeavor to raise our sights yearly.

Reference Committee Recommendation—Scientific Exhibit Awards Committee report is accepted and approved.

House of Delegates Action—Adopted the Scientific Exhibit Awards Committee report as recommended by the reference committee on motion duly made and seconded.

Hospital Relations Committee

MILFORD B. HATCHER, M.D., Macon, *Chairman*

The main activities of the Hospital Relations Committee of the Medical Association of Georgia have for the most part of the year been as liaison with the Georgia Hospital Association, Hospital Trustees Association, and the State Health Department.

This has been mainly the Georgia Hospital Care Study Commission and recommendations for appropriate legislation.

Reference Committee Recommendation—Hospital Relations Committee report is accepted and approved.

House of Delegates Action—Adopted the report of the Hospital Relations Committee as recommended by the reference committee on motion duly made and seconded.

ADDENDUM NO. 4—RURAL HEALTH COMMITTEE

J. L. WALKER, M.D.

Since the initial report, the committee has met at Rock Eagle, on April 3, and at this time an official Advisory Committee was appointed as follows: Miss Lucile Higginbotham, Health Education Specialist; Rev. Edward A. Driscoll, Georgia Council of Churches; Miss Marian Fisher, Assistant 4-H Leader; Mr. William A. King, District Agent; Miss Leah Mae Jarrett, Georgia 4-H Council; Mrs. Rufus Slaughter, Georgia Home Demonstration Council; and two members from the Farm Bureau will be appointed later.

The session proved to be very fruitful, and many more projects were proposed than we will be able to do without much time and effort. The proposals were as follows:

1. The great need for a check list to guide rural people in purchasing voluntary prepaid medical and hospital insurance. The committee agreed to prepare such a check list and it will be distributed through the channels available to members of the Advisory Committee.

2. We were requested to make *Today's Health* more generally available to rural high schools, public libraries, etc.

3. We were requested to make available films for use in rural groups to help teach health. This will be done by headquarters in cooperation with AMA and films will be available through extension service.

4. We were requested to write a monthly column on timely health subjects, to be published in weekly papers and distributed through the Advisory Committee.

5. We recommend to the Georgia Council of Churches that they stimulate the development of chaplain services and chapels of worship in all hospitals in the state.

6. The need for a health record card was discussed, and it was brought out that the AAGP now is processing such a card. All members of the Advisory Committee requested that such cards be made available for distribution.

7. The Advisory Committee stated that if the brochure regarding paramedical personnel were made available they could and would use it to great advantage in helping to recruit personnel.

It was decided to have a meeting twice yearly with the Advisory Committee, and the next meeting is to be in September.

On May 1, a program for training practical nurses at North Georgia Trade and Vocational School in Clarksville, Georgia, is to be instituted. The first class will probably be started about July 1. Information can be obtained by having prospective students write to the director at the above address. This school will be open to all Georgia citizens and no tuition is charged.

I wish to thank Mr. Krueger and the headquarters staff for the fine cooperation they have given this committee. However, I have observed that the demand for services is increasing rapidly, and I feel certain that our committee alone will require much more work from the staff as our activities expand. This is a serious matter, and I feel that additional help is needed now in headquarters if our programs are to expand as they must.

I wish to recommend that in the future this committee as well as all other standing committees be appointed by Council and that terms be staggered so that there may be a better continuity of work.

Reference Committee Recommendation—Addendum No. 4, to the Rural Health Committee report, is accepted and approved, and again we wish to strongly emphasize that the suggestions presented by this committee be carried out as completely as possible.

House of Delegates Action—Adopted Addendum No. 4, to the Rural Health Committee report, as recommended by the reference committee on motion duly made and seconded.

Resolution No. 4

Federal Medical Expenditures

H. BAGLEY BENSON, M.D., Atlanta

WHEREAS, the amount of money being spent by the federal government for health and welfare purposes has reached truly astronomical levels, and

WHEREAS, the budget for federal expenditures for the next year exceeds all others in peace time, and

WHEREAS, the Department of Health, Education, and Welfare has made numerous grants and gifts to a large number of individuals and organizations for research projects that seem to be of limited or nominal value,

THEREFORE BE IT RESOLVED that the Medical Association of Georgia go on record as opposing such free spending except for those projects generally considered to be of unquestionable value, and that our representatives in Congress be informed of this action and requested to support this position.

Reference Committee Recommendation—Resolution No. 4, on Federal Medical Expenditures, accepted and approved.

House of Delegates Action—Adopted Resolution No. 4, on Federal Medical Expenditures, as recommended by the reference committee on motion duly made and seconded.

Resolution No. 6

VA Hospital Construction

TULLY T. BLALOCK, M.D., Atlanta

WHEREAS, it is a fact that the physicians in the United States have on occasion dedicated themselves to the policy that veterans of the Armed Forces who served during any and all wars, "police actions" and similar conflicts of any type, participated in by our country, shall have the best possible medical care for injuries and illnesses incurred as a result of, or aggravated by their military duties, and

WHEREAS, it has been both the policy and the practice of American physicians to provide, regardless of costs, all medical care required for the treatment of

conditions resulting from illness and accidents, of all veterans, regardless of any connection with military service, the same as it does for all other classes of American citizens, and

WHEREAS, American physicians through the American Medical Association and related organizations, have supported, both as tax-payers as well as physicians, the general over-all policy of the Veterans Administration to provide the best medical care for service-connected medical conditions, and

WHEREAS, the total number of beds now available in hospitals administered by the Veterans Administration for the care of veterans with service-connected disabilities is known to be considerably in excess of actual needs for such purpose, as evidenced by the fact that the majority of beds in most, if not all, Veterans Hospitals are now used for non-service connected disabilities,

THEREFORE BE IT RESOLVED that the Medical Association of Georgia approve the construction of new hospitals and additional beds in this and other states only where it can be proved that actual need exists for the care of service-connected disabilities, true bona-fide emergencies, and care for such "needy" or medically indigent veterans who are without income or property beyond their basic needs.

BE IT FURTHER RESOLVED that the deans committees and members of medical college faculties who participate in the supervision, management, and direction of residency training programs in Veterans Administration hospitals be specifically requested to adhere to and conform with this policy.

BE IT FURTHER RESOLVED that the Medical Association of Georgia delegates to the American Medical Association be instructed to present a similar resolution to the House of Delegates of that organization requesting that similar action be taken by the American Medical Association, and that its Council on Medical Education and Hospitals be requested to use its influence to have all medical college faculties cooperate with this policy.

Reference Committee Recommendation—Resolution No. 6, on VA Hospital Construction, is accepted and approved.

House of Delegates Action—Adopted Resolution No. 6, on VA Hospital Construction, as recommended by the reference committee on motion duly made and seconded.

Speaker Goodwin then called for any further business, and there being none, the reconvened session of the House of Delegates of the Medical Association of Georgia of the *103rd Annual Session was adjourned at 5:45 p.m., April 30, 1957.

General Business Session (Second Session)

Wednesday, May 1, 1957

THE SECOND GENERAL BUSINESS SESSION of the *103rd Annual Session of the Medical Association of Georgia was called to order by President Hal M. Davison, Atlanta, at 10:30 a.m., Ballroom, Hotel DeSoto, Savannah, Georgia.

President Davison announced that the official attendance at this *103rd Annual Session was as follows: MAG members, 580; M.D. guests, 77; other guests, 18; and, exhibitors, 135, for a grand total of 810 registrants.

President Davison commended Council Annual Session General Chairman J. G. McDaniel, Atlanta; Meeting Room and Scientific Exhibits Arrangements Chairman Ted F. Leigh, Atlanta; and Commercial Exhibits Arrangements Chairman Peter Hydrick, College Park. Dr. Davison, on behalf of the members, also commended the Local Arrangements Committee of the Georgia Medical Society, which included T. A. Peterson, Savannah, chairman; and W. Loyd Osteen, Savannah, Co-Chairman. L. M. Freedman, David Robinson, Jules Victor, Jr., and John G. Sharpley of the Georgia Medical Society were thanked for their activity in local arrangements, as was Walter Brown, President of the Georgia Medical Society.

Scientific Exhibit Awards

President Davison called on Ted F. Leigh, Chairman of Scientific Exhibit Awards, for his report and the presentation of the Scientific Exhibit Awards. Dr. Leigh read the report of the secret committee for judging the scientific exhibits at the Medical Association of Georgia Annual Session, 1957, as follows:

First Place Award—"Infertility: Diagnosis and Treatment"—

R. B. Greenblatt, Joan Landry, B.A., Edwin Jungck, and W. E. Barfield, Augusta, Georgia.

Second Place Award—"Hysterosalpingography—Gross Pathology"—

Henry E. Steadman, Hapeville, Georgia.

Third Place Award—"Rectal Polyp"—

Leonard J. Rabhan, Savannah, Georgia.

Honorable Mentions—

"Carcinoma of the Thyroid: Surgical Management"—

David Henry Poer, John E. Skandalakis, and Edgar O. Rand, Atlanta, Georgia.

"Interesting ORL Cases"—

Ponce de Leon Infirmary, Atlanta, Georgia.

"A Comparative Study of Synthetic Material As Vascular Prostheses"—

J. Harold Harrison, Atlanta, Georgia.

Fifty Year Certificates

President Davison called on W. Bruce Schaefer, Toccoa, for the presentation of "Fifty Year Certifi-

cates" to physicians who have practiced medicine for 50 years or more. These presentations were made to the following physicians: William S. Cook, Albany; J. George Bachmann, Atlanta; Montague L. Boyd, Atlanta; Frank L. Eskridge, Atlanta; Clarence A. Rhodes, Atlanta; Guy T. Bernard, Augusta; Clyde A. Stevenson, Camilla; Henry L. Sams, Dalton; Julius C. Stone, Doerun; George T. Banks, Fairmount; Robert F. Cary, Macon; John L. Garrard, Rome; Virgil C. Cooke, Savannah; C. G. Redmond, Savannah; Harry Y. Righton, Savannah; C. C. Giddens, Valdosta; Orlando S. Wood, Washington; Daniel M. Bradley, Waycross; Ernest R. Harris, Winder; Edward M. McDonald, Winder; Thomas J. Vansant, Woodstock.

Hardman Award

President Davison called on Sue Hardman Ivey, Nashville, Tennessee, for the presentation of the "Hardman Award." Dr. Ivey presented the award to J. W. Chambers of LaGrange, who because of illness was unable to attend. The cup and certificate were received by Roy L. Gibson of Columbus for Dr. Chambers.

GP of the Year

President Davison called on A. G. LeRoy of Thomson to present the "1957 Georgia General Practitioner of the Year Award" to F. B. Pickett of Ty Ty.

Certificates of Appreciation

President Davison called on David Henry Poer for the presentation of Certificates of Appreciation.

Dr. Poer called on Walker L. Curtis, College Park, to present an Association Certificate of Appreciation for service as President of the Woman's Auxiliary to the Medical Association of Georgia to Mrs. Walker L. Curtis.

Dr. Poer called on Mrs. Hal M. Davison to present an Association Certificate of Appreciation to Hal M. Davison for service to the Medical Association of Georgia as President.

Dr. Poer called on Lee Howard to present an Association Certificate of Appreciation to J. Calvin Weaver for his service to the Medical Association of Georgia as Chairman of the History and Vital Statistics Committee.

Dr. Poer called on A. W. Simpson, Washington, to present an Association Certificate of Appreciation to Harry L. Cheves for his service to the Medical Association of Georgia as Councilor from the Tenth District.

Dr. Davison presented to David Henry Poer an Association Certificate of Appreciation for service to the Medical Association of Georgia as Secretary-Treasurer, 1951-57.

Golf Awards

President Davison called on T. A. Peterson for the presentation of the Golf Awards, which are as follows:

Low Net—F. G. Eldridge, Valdosta.
Second Net—Van B. Bennett, Valdosta.
Low Gross—Lucius Smith, Rome.
High Gross—Thomas W. Goodwin, Augusta.
High Blind—Rafe Banks, Gainesville.
Low Blind—G. D. Scheussler, Columbus.

Dr. Poer then presented President Hal Davison with a bound volume of the 1956-57 *Journal of the Medical Association of Georgia*.

1958 Meeting Site

President Davison announced that the next order of business was the selection of a 1958 meeting site, and Henry H. Tift, Macon, rose to present an invitation on behalf of the Bibb County Medical Society for the Medical Association of Georgia to hold its 1958 Annual Session in Macon. By unanimous vote it was approved that the Association accept the gracious invitation of the Bibb County Medical Society.

Election Result

President Davison then called on Tellers Committee Chairman Pomeroy who announced that the only contested office was that of AMA Delegate and by ballot the members had elected Charles H. Richardson, Macon. Grady N. Coker moved, and it was duly seconded, that the election of Charles H. Richardson as AMA Delegate be made unanimous by a rising vote, and it was so approved.

Installation of Officers

Installation of 1957-58 Officers—The next order of business was the installation of 1957-58 officers, which are as follows:

President—W. Bruce Schaefer, Toccoa.
President-Elect—Lee Howard, Sr., Savannah.
Immediate Past President—Hal M. Davison, Atlanta.
First Vice-President—T. A. Peterson, Savannah.
Second Vice-President—Hugh Bickerstaff, Columbus.
Secretary—Chris J. McLoughlin, Atlanta.
AMA Delegate (term beginning January 1, 1958)—C. H. Richardson, Macon.
AMA Alternate Delegate (term beginning January 1, 1958)—J. W. Chambers, LaGrange.
Ninth District Councilor (1956)—Charles R. Andrews, Canton.
Ninth District Vice-Councilor (1960)—Paul Scoggins, Commerce.
Tenth District Councilor (1960)—Addison W. Simpson, Jr., Washington.
Tenth District Vice-Councilor (1960)—David R. Thomas, Jr., Augusta.

President Davison turned the gavel over to President W. Bruce Schaefer, for the installation of those officers.

President W. Bruce Schaefer then delivered an address, and upon completion of his remarks the meeting was adjourned at 12:05 p.m.

Council and Executive Committee Minutes

Final Meeting, 1956-57 Council, April 27, 1957

THE FINAL MEETING of the 1956-57 Council of the Medical Association of Georgia was called to order at 7:30 p.m. by Chairman George R. Dillinger.

Present were: Hal M. Davison, Atlanta, President; W. Bruce Schaefer, Toccoa, President-Elect; Bernard P. Wolff, Atlanta, 2nd Vice-President; David Henry Poer, Atlanta, Secretary-Treasurer; Thomas W. Goodwin, Augusta, Speaker of the House; and Councilors Lee Howard, Savannah, 1st District; George R. Dillinger, Thomasville, 2nd District; W. G. Elliott, Cuthbert, 3rd District; Luther H. Wolff, Columbus, 3rd District Vice-Councilor; J. G. McDaniel, Atlanta, 5th District; Henry H. Tift, Macon, 6th District; George H. Alexander, Forsyth, 6th District Vice-Councilor; Ralph W. Fowler, Marietta, 7th District Vice-Councilor; F. G. Eldridge, Valdosta, 8th District; Charles R. Andrews, Canton, 9th District; Harry L. Cheves, Union Point, 10th District; A. W. Simpson, Washington, 10th District; Walter Brown, Savannah, President, Georgia Medical Society; Messrs. Krueger and Kiser, Headquarters Office, Atlanta; Chris J. McLoughlin, Atlanta, Chairman, Public Relations Committee; T. A. Peterson, Savannah, Chairman, Local Arrangements Committee.

Following an invocation by Chairman Dillinger, the minutes of the March 9-10 Council meeting, the March 14th Executive Committee meeting (conference phone call), and the minutes of the April 14th Executive Committee meeting were read by Mr. Krueger.

It was voted to approve the Executive Committee action of March 14, 1957.

In discussing the April 14 Executive Committee minutes, the problem of the five per cent rise in printing costs was discussed. It was voted that this matter be referred to the first regular business session of the new 1957-58 Council.

It was voted to approve all minutes as corrected.

Medicare—Dr. Poer discussed the general operational policies of the new Medicare program and stated that progress to date was satisfactory. Mr. Krueger discussed some of the problems in the administration of the Medicare program. After discussion, this information was accepted.

A recommendation by the Review Board was as follows: "That the Medicare Review Board recommend to the Council of the Medical Association of Georgia that the problems of administrative expenditures in the operation of the Medicare program be determined by said Review Board insofar as they do not exceed the allowable costs per claim rate." This was referred to the 1957-58 Council.

Professional Conduct Committee Report—A letter was read from A. M. Phillips, Macon, Chairman of the Professional Conduct Committee, in connection with the problem of nurses' prescribing and administering medicine without orders of a physician. This matter was referred to the new 1957-58 Council.

Council Finance Committee Report—J. G. McDaniel, Chairman of the Finance Committee, reported that the Association deficit would be approximately \$6,500 to \$7,000 in 1957. He discussed additional necessary funds for the Crawford W. Long Memorial. Dr. Dillinger pointed out that the Association might even incur a \$12,000.00 deficit. A motion by Dr. Goodwin that Council recommend to the House of Delegates a raise in dues of \$25.00 was withdrawn after considerable discussion. Dr. Poer suggested that the dues be raised the following year when Council will have more information on the financial status of the Association.

Medical Defense Statements—Mr. Krueger read two letters from Mr. Dunaway re: William E. Campbell and Exum Walker in regard to recent medical defense cases and Council approved the bills submitted from Mr. Dunaway for these cases.

Dr. Tift asked that the MAG assist the Bibb County Medical Society in payment of an attorney's fee in connection with a legal brief filed. It was moved that the MAG pay \$150.00 to the Bibb County Medical Society. This motion was disapproved.

Practical Nurses Board Appointments—Mr. Krueger read a letter from the practical nurses board requesting nominations for the Board's Advisory Committee. Grady N. Coker, Canton, and A. M. Phillips, Macon, were nominated for this position, one of these men to be selected by the Governor to fill the post.

Unfinished Business—Dr. Eldridge presented a resolution from the Eighth District Medical Society concerning Medicare as follows:

"WHEREAS, the Medical Association of Georgia has assumed a unique position in the handling of the 'Medicare' program, and

"WHEREAS, many flaws have apparently developed in the function of the program in Georgia, which have caused dissatisfaction among the doctors of Georgia and have brought about much criticism of the Headquarters Office of the Medical Association of Georgia, and

"WHEREAS, the basic function of the Council and Headquarters Office is the administration of the Medical Affairs of the Association and not the running of an insurance business,

"THEREFORE, BE IT RESOLVED that the Eighth District Medical Society requests that the Council of the Medical Association of Georgia investigate the possibility of sub-letting the administration of Medicare to an appropriate agency experienced in insurance matters or to set up better facilities for handling the program more efficiently.

"It is further suggested by this society that a full fee schedule be furnished to each practicing physician in Georgia as soon as available."

It was voted to refer this resolution to the 1957-58 Council.

Dr. Goodwin discussed the need for a committee to study the reorganization of the MAG Committee or-

ganization and a committee to study the re-districting of the state as far as representation on Council is concerned. It was voted to refer these two matters to the 1957-58 Council.

First Meeting, 1957-58 Council, May 1, 1957

GEORGE R. DILLINGER, Thomasville, 1956-57 Chairman of Council, called the 1957-58 organizational meeting of the Council of the Medical Association of Georgia to order at 11:45 a.m., May 1, 1957 in the Ballroom of the Hotel DeSoto, Savannah, Georgia.

Council members present included: W. Bruce Schaefer, Toccoa, President; Lee Howard, Sr., Savannah, President-Elect; Hal M. Davison, Atlanta, Immediate Past President; T. A. Peterson, Savannah, 1st Vice-President; Chris J. McLoughlin, Atlanta, Secretary; Thomas W. Goodwin, Augusta, Speaker of the House; Charles T. Brown, Guyton, Councilor, 1st District; George R. Dillinger, Thomasville, Councilor 2nd District; W. G. Elliott, Cuthbert, Councilor, 3rd District; J. G. McDaniel, Atlanta, Councilor, 5th District; Henry H. Tift, Macon, Councilor, 6th District; Ralph W. Fowler, Marietta, Vice-Councilor acting for D. Lloyd Wood, 7th District; F. G. Eldridge, Valdosta, Councilor, 8th District; Charles R. Andrews, Canton, Councilor 9th District; and Addison W. Simpson, Jr., Washington, Councilor, 10th District. Also present was Mr. M. D. Krueger, Atlanta, Executive Secretary.

Chairman Dillinger introduced the new officers and councilors which included Lee Howard, President; T. A. Peterson, 1st Vice-President; Charles T. Brown, 1st District Councilor; and Addison W. Simpson, 10th District Councilor.

Nominations for Chairman of Council—Dr. Dillinger turned the gavel over to W. Bruce Schaefer. George R. Dillinger was nominated chairman of Council for the year 1957-58. There were no other nominations. Dr. Dillinger then resumed the chair as Chairman.

Nominations for Vice-Chairman of Council—J. G. McDaniel, Atlanta, was nominated for Vice-Chairman. There being no other nominations, this nomination was approved.

Appointment of Council Committee on Finance—Chairman George R. Dillinger appointed J. G. McDaniel, Atlanta, Chairman of the Council Finance Committee, with J. W. Chambers, LaGrange, and Charles Andrews, Canton, as members.

Chairman Dillinger then recessed the Organizational

Council meeting. Chairman Dillinger reconvened the Organizational Council meeting and informed the Council that at the Executive Committee meeting during the recess the Executive Committee appointed Chris J. McLoughlin treasurer of the Association for the year 1957-58, subject to the approval of Council. It was moved that Council approve the appointment of Dr. McLoughlin as Treasurer of the Association for the year 1957-58.

MAG Journal Printing Costs—After discussion of a proposed June 1 five per cent increase in the printing costs of the *Journal of the Medical Association of Georgia* it was moved that this increase be approved. The motion was then approved.

Site and Date of Next MAG Council Meeting—By general agreement it was approved that the Council of the Medical Association of Georgia would meet June 15-16, 1957, in Macon, Georgia.

1958 Annual Session—It was moved that either April 13, 14, 15, and 16, 1958, or April 27, 28, 29, and 30, 1958, be selected as the date of the 1958 Annual Session of the Association, and further that Dr. Tift and Mr. Krueger be empowered to act on either of these dates.

MAG Current Expense and Medicare Claim Checks—By general agreement it was duly moved, seconded and approved that the Secretary-Treasurer, Chris J. McLoughlin, be authorized to pay current expenses and sign medicare claim checks.

Legal Counsel—It was moved that the firm of Alston, Miller, Sibley, Spann and Shackelford be retained for legal counsel as instructed by the House of Delegates concerning the Revised Waters Resolution action. Motion approved. It was also recommended that prior to the June 15-16, 1957, Council meeting each member of Council be sent the Revised Waters Resolution as adopted by the House of Delegates and the Medical School Ethics Committee report.

There being no further business, the meeting adjourned at 1:00 p.m.

1957-58 Executive Committee Meeting, May 1, 1957

CHAIRMAN GEORGE R. DILLINGER called the first meeting of the 1957-58 Executive Committee of Council to order at 12:05 p.m. in the Ballroom of the Hotel DeSoto, Savannah, Georgia, May 1, 1957.

Members present were: W. Bruce Schaefer, President; Lee Howard, Sr., President-Elect; Hal M. Davison, Immediate Past President; Chris J. McLoughlin, Secretary; George R. Dillinger, Chairman of Council; and J. G. McDaniel, Chairman of Finance Committee.

Dr. Dillinger introduced the new members: Dr. Howard and Dr. McLoughlin.

Appointment of Treasurer—It was moved that Chris McLoughlin be appointed treasurer of the Association for the year 1957-58. Motion approved.

Site and Date of Next Meeting—It was approved that the Executive Committee of Council meet concurrently with the Council at the June 15-16, 1957, meeting to be held in Macon, Georgia.

There being no other business, Chairman Dillinger adjourned the meeting at 12:25 p.m.



Diagnosis of Subacute Bacterial Endocarditis

ROBERT L. WHIPPLE, JR., M.D., Atlanta, Ga.

ALTHOUGH A POSITIVE blood culture is paramount in the diagnosis of bacterial endocarditis, the clinical features include such a constellation of symptoms and findings that, as a rule, the condition can be recognized by history and physical examination alone. It is of vital importance that an early diagnosis be made, for cure may be effected by the proper antibiotic in proper dosage, and the patient may be as well as before the implantation took place. Bacteria capable of producing subacute bacterial endocarditis commonly enter the blood stream after tooth extraction, operations on the nasopharynx, genitourinary manipulations and operations, and operations on the rectum; and it is essential that prophylaxis be carried out in those patients with cardiac lesions who have these procedures done, and also these patients should be watched for several weeks thereafter.

While persistent fever is the rule, no special type of fever is characteristic of the disease. There may be low, irregular elevations, or spiking fever of intermediate degrees with afebrile periods. Chills, chilly sensations, and night sweats are frequent accompaniments of fever, and patients have malaise, anorexia, weight loss, and aching in various muscles and joints.

Since the essence of the disease is the implantation of bacteria on a previously damaged endocardium, or at the site of a congenital lesion, evidence of a cardiac lesion, in form of a murmur, is present sooner or later in 99 per cent of patients. In less than five per cent of cases bacterial implantation occurs on what are valves seemingly undamaged by previous disease.

Petechiae are of special importance, and search should be carefully made for they can occur at any site of the body. The lesions are small, dark, erythe-

matous lesions and frequently have a tiny white center. Petechiae should be differentiated from punctate telangiectases. The latter are bright red and do not fade in a day or two as petechiae do. Painful, pea-sized or smaller, tender swelling of the pad of a finger or toe, and larger, slightly elevated, painless hemorrhagic areas in the skin of the palms or soles are highly suggestive but usually occur late in the course of the disease. Splinter hemorrhages and hemorrhages in the eyegrounds add weight to the diagnostic possibility.

The spleen is nearly always palpable even in the early cases of bacterial endocarditis. The enlargement is not great, and it is tender if splenic infarction or emboli have occurred.

Clubbing of the fingers develops early in many patients. Extreme degrees are rarely found, but early clubbing as evidenced by edema and looseness of the nail beds should be looked for. If the findings are interpreted with caution and the existence of congenital clubbing recognized, the sign is helpful in distinguishing bacterial endocarditis from rheumatic fever, for it is not associated with uncomplicated rheumatic fever.

Embolic phenomena occur at some time in most cases, and the effects of the embolic are of greatest importance in diagnosis. The clinical symptoms and findings are varied. They depend on the location of the occluded vessel and whether or not added thrombus formation has occurred, or whether a mycotic aneurysm has formed with subsequent rupture. Patients with bacterial endocarditis in the left heart may, of course, like anyone chronically ill, have pulmonary emboli originating in phlebothrombosis of the leg veins.

Blood cultures with isolation of the responsible organism is paramount in the diagnosis of bacterial

Prepared at the request of the Committee on Professional Education of the
Georgia Heart Association

Noblesse Oblige

WHILE ATTENDING A MEDICAL MEETING a few months ago, I met a friend whom I had not seen since our intern days together. After exchanging the usual pleasantries, I was appalled to note certain changes in him. I don't have reference to those physical ones that come with time inevitably, but to a certain metamorphosis of manner and outlook on life. True, nothing is static; change is constant and growth is good. But are we developing or deviating?

This fellow was obviously affluent and prosperous but disturbingly aloof and surrounded with an aura of "untouchable greatness." He overwhelmed me with advice on how to achieve "the large and successful practice," regardless of the toes that were trod upon in the process. He assured me that all your competitors were out to "cut your throat."

It was clear that success had not brought him security. As far as I was concerned, he was a miserable failure. Gone were qualities I had found admirable when he was secure within the four walls of a large institution. The little niceties and tact towards his fellowman were apparently long in disuse—in short, he had simply forgotten how to be kind and courteous.

Observing him thus, it occurred to me that with the achievement of a successful practice, we all may have unintentionally acquired what can only be termed a few bad manners. In our relationships with other physicians let's take time to be courteous. In telephoning a colleague, place the call yourself rather than have your secretary make the contact. Respect the fact that he is busy too, and not a menial to be

summoned by your assistant. When requesting a consultation, it is much more polite to ask the consultant yourself, rather than have a floor nurse impersonally call in the message.

When another doctor thinks enough of your medical prowess to send a member of his family to see you, return the compliment by seeing them promptly.

In public, remember to use tact and discretion when another member of your profession is being discussed. Generosity and diplomacy reap far greater rewards than the sly innuendo which is completely out of place and in extremely bad taste. There is a niche for each of us, and competition should serve to sharpen our senses rather than dull our wits.

When we are called in consultation, allow the attending physician to speak first with the family. It is his job, not the consultant's. Where there is a difference of opinion settle it with the referring doctor, before the family is placed in the bewildering position of wondering who is right. After all, we are here to serve the best interest of the patient and not our egos.

Egomania is a terrible disease, the etiology of which is basic insecurity. Fortunately it is not always malignant, and the therapy is simple. A daily dose of the Golden Rule is sufficient. It is never too late to find a place in our habit-stricken souls for those gentler influences which make life worth living.

Clarence Butler, M.D.

Reprinted from the *Bulletin of the Muscogee County Medical Society*, February 1957, with permission of the editor.

Subacute Bacterial Endocarditis (cont'd)

endocarditis, and in the great majority of cases positive blood cultures can be obtained. A series of four to six blood cultures taken at hourly intervals should be obtained. Close cooperation and verbal consultation between the physician and bacteriologist responsible for cultures and antibiotic sensitivity tests is essential for proper diagnosis and management.

The presence of microscopic hematuria with or without albuminuria can be found in the great majority of cases and represents either the so-called focal embolic glomerulonephritis or what is indistinguishable from the usual varieties of glomerulonephritis. The urine may show no abnormality, yet at times there may be bursts of frank renal bleeding

with flank pain associated with embolism and infarct of the kidney.

Most patients develop progressive and sometimes extreme anemia. The usual leukocyte count is elevated, however, it may be as low as 2,000 or as high as 30,000 to 50,000 per cubic millimeter. An increase in number of monocytes as well as large phagocytic cells presumed to be reticuloendothelial in origin have been noted. Some elevation of gamma globulin fraction is always found, and an increase in the sedimentation rate as well as C-reactive protein is usual except in the very earliest stages.

If one is suspicious and the above is kept in mind, the early diagnosis of subacute bacterial endocarditis will be made.



Books Received

Alvarez, Walter C., M. D.; Clegg, Hugh, M.D.; Marti-Ibanez, Felix, M.D.; Selye, Hans, M.D.; and Sigerist, Henry E., **MEDICAL WRITING**, M.D. Publications, Inc., New York, 1956, 66 pp.

CODE OF GEORGIA ANNOTATED, STATE OF GEORGIA, WORKMEN'S COMPENSATION ACT, The Harrison Company, Publishers, Atlanta, 1956, 177 pp.

Slaughter, Frank G., **SWORD AND SCALPEL**, Doubleday and Company, Inc., New York, 1957, 285 pp., \$3.75.

Gosnell, Cullen B., and Anderson, C. David, **THE GOVERNMENT AND ADMINISTRATION OF GEORGIA**, Thomas Y. Crowell Company, New York, 1956, 389 pp., \$5.75.

Leedy, Paul D., **READING IMPROVEMENT FOR ADULTS**, McGraw-Hill Book Company, Inc., New York, 1956, 452 pp., \$5.95.

Reviews

Barrow, Roscoe L. and Fabing, Haward D., M.D., **EPILEPSY AND THE LAW, A PROPOSAL FOR LEGAL REFORM IN THE LIGHT OF MEDICAL PROGRESS**, a Haeber-Harper Book, New York, 1956, 140 pages.

A lawyer and a physician have collaborated in bringing together information on epilepsy and the law in this volume. The book covers marriage license laws, sterilization laws, drivers' license laws, workmen's compensation laws, and many miscellaneous laws affecting epileptics.

The book gives one a clear-cut picture of the inadequacies that make the epileptic's position in society so insecure, and shows what steps must be taken to make the situation conform with modern medical knowledge.

Under the chapter regarding sterilization laws, the authors decry "forcing epileptics into the same legal mold with idiots and the insane." Seventeen states have eugenic sterilization laws which are specifically applicable to epileptics, "and the statute of an additional state (Georgia) has been construed to apply to epileptics."

According to this chapter, Georgia is one of four states in which sterilization of epileptics is still practiced to some extent, and yet, the book points out, none of the sterilization statutes contains a definition of "epilepsy". "Such a serious invasion of the person and personality as sterilization would seem to call for a statutory definition of the class to which the law applies."

The volume calls for the amendment of sterilization laws so as to render them inapplicable to epileptics.

The other chapters regarding workmen's compensation, marriage laws, and drivers' license laws are equally interesting.

Young, Agatha, **SCALPEL: MEN WHO MADE SURGERY**, Random House, New York, 1956, 301 pages, \$5.00.

This book relates the development of surgery from the "discovery" of human anatomy to the present day. It describes the lives and contributions of Vesalius, Pare, Harvey, Hunter, McDowell, Lister, Halsted, Cushing, and the great anesthetists. It is given in a highly biographical style with many of the interesting sidelights and personal facts about the various great men.

The section of the book of most interest to physicians

in Georgia is the one concerning "The Anesthetists," a description of the work of Crawford W. Long, and Wells, Morton, and Jackson.

After describing Dr. Long's first operation performed under ether without pain, the author comments, "... what did Dr. Long do about his great discovery? Nothing at all. He made no announcement of any sort either in the interest of his own glory or to aid suffering mankind. Years later, when he was trying to have himself recognized as the discoverer of ether, he sought to excuse his failure to make his discovery public on the grounds that he was waiting to see if any other doctor had made the same discovery." The author devotes four paragraphs to a discussion of Dr. Long's work and approximately 17 pages to a discussion of the work of Morton, Wells, and Jackson.

A particularly interesting section of the book is that relating to Halsted and Cushing: Halsted's various idiosyncrasies and Cushing's letters to his mother describing Dr. and Mrs. Halsted and their life in Baltimore.

Kelley, Stanley, Jr., **PROFESSIONAL PUBLIC RELATIONS AND POLITICAL POWER**, The Johns Hopkins Press, Baltimore, 1956, 235 pages, \$4.50.

This is a fascinating book about the power of publicity and propaganda in political campaigns. The book describes the role of public relations in moulding and influencing public opinion in regard to legislative issues and governmental problems. An entire chapter is devoted to the Whitaker and Baxter campaign conducted for the AMA, 1949 to 1952, to effectively defeat Truman's proposed national compulsory health insurance plan. The author describes early experiences of the Whitaker and Baxter public relations company with the California Medical Association in defeating a similar statewide program sponsored by Governor Earl Warren. It describes in detail the development of the National Education Campaign and gives the various techniques and procedures used in contacting almost every person in the United States during the two years.

Also described is the Senatorial race between Herbert Lehman and John Foster Dulles in which "Socialized Medicine" was an important issue. The same chapter touches on the senatorial races in Florida involving Claude Pepper and Frank Graham in North Carolina.

"In the 1950 Congressional election, campaigning doctors played a part in the defeats of Senators Elbert Thomas of Utah and Scott Lucas of Illinois and Representatives Biemiller of Wisconsin and O'Sullivan of Nebraska. They work strongly in behalf of Senator Eugene Millikin in Colorado and Senator Robert A. Taft in Ohio."

It is interesting to note that the Whitaker and Baxter Campaign seemed to lead directly to the formation of the National Professional Committee for Eisenhower-Nixon in September 1952. This committee included prominent members of the medical, dental, legal, accounting, and engineering professions, but its chairman was Dr. Elmer Henderson, who had been chairman of the AMA's National Educational Campaign.

INFORMATION

ANNOUNCEMENTS

Southern Pediatric Seminar—Pediatrics: July 8-13; Pediatrics and Internal Medicine: July 15-20; and Obstetrics and Gynecology: July 22-27, 1957, Saluda, N.C. Credit for attendance is accepted, hour for hour, by the AAGP, Category I. Accommodations may be had by communicating with the secretary-treasurer. Registration fee: \$35.00 per week. Advance registration is requested, classes are limited to 125. Expenses are tax deductible. For information and registration, address M. A. Owings, Secretary-Treasurer, Saluda, N. C.

9th Postgraduate Assembly in Endocrinology and Metabolism—October 21-25, 1957, Medical College of Georgia, Augusta, Ga. Faculty will consist of 22 clinicians and investigators in the fields; course is designed to cover the main aspects of diagnosis and therapy for the physician in general practice. Approved by the AAGP for 35 credit hours in Category I. For further information concerning the program and registration, write to Dr. Robert B. Greenblatt, Dept. of Endocrinology, Medical College of Georgia, Augusta, Ga. Registration is limited to 100; tuition fee is \$100.00. Rooms will be reserved for students and faculty at the Bon Air Hotel. Residents and fellows will be admitted for \$35.00.

District IV, American College of Obstetricians and Gynecologists—October 4 and 5, 1957, Washington, D. C. The areas comprising this district are: D. C., Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia, Puerto Rico, and the Virgin Islands. Physicians are invited to attend the scientific and social functions of the meeting; additional information may be obtained by writing Frank R. Lock, M.D., Bowman Gray School of Medicine, Winston-Salem, N. C., District Chairman, or Robert H. Barker, M.D., 901 - 23rd St., N.W., Washington, D. C., Chairman of the Program.

Annual Assembly in Otolaryngology, University of Illinois College of Medicine—September 30-October 6, 1957, Section of Otolaryngology,

Univ. of Ill. College of Medicine. The Assembly will consist of an intensive series of lectures and panels concerning advancements in otolaryngology, and evening sessions devoted to surgical anatomy of the head and neck in histopathology of the ear, nose and throat. Interested physicians should write direct to the Department of Otolaryngology, 1853 West Polk St., Chicago 12, Ill.

Seventh American Congress on Maternal Care—July 8-12, 1957, Palmer House, Chicago. The congress, under the leadership of F. Bayard Carter, M.D., professor and head of the department of obstetrics and gynecology at Duke University, and Samuel B. Kirkwood, M.D., Commissioner of Public Health for the Commonwealth of Massachusetts and professor of maternal health at Harvard Medical School, will present topics dealing with the inter-professional approach to maternal and infant care. Further information can be obtained by writing: The American Committee on Maternal Welfare, 116 South Michigan Ave., Chicago 3, Ill.

Films Available

"Meti" Steroids in Rheumatoid Arthritis—A new 16 mm. color motion picture on the uses of steroids in the treatment of rheumatoid arthritis has been released for showing to professional groups by the research division of Schering Corporation. The film runs 25 minutes and is the fourth in Schering's series on hormone therapy and the endocrines. It is available on loan from the Audio-Visual Dept., Schering Corp., Bloomfield, N. J.

"Urine Sugar Analysis for Diabetics"—The film was made as a visual aid to be used in the education of diabetic patients and shows the relationship between carbohydrates and insulin. Produced on 16 mm. film in color and sound track with a running time of approximately 10 minutes. Showings at diabetic clinics, diabetic lay societies and other diabetic groups must be requested by the medical or allied professions to Ames Company, Inc., Elkhart, Ind., or an Ames representative.

"The Medical Witness" and "The Doctor Defendant"—The A. M. A.

and the American Bar Association have joined forces for the first time to present a series of educational films on "Medicine and the Law" dealing with the professional relationships of doctors and lawyers. Each film runs 30 minutes, is black and white with sound, on 16 mm. film. The series is produced by The William S. Merrell Co., Cincinnati, Ohio, as a service to the medical and legal professions. Societies desiring to show either or both films may write to the Film Library, A. M. A., 535 North Dearborn St., Chicago 10, Ill.

DEATHS

RALPH E. HAMILTON, Douglasville, died on March 30, 1956, after an illness of several weeks. He is survived by his wife, the former Miss Edna Malone, of Villa Rica.

Dr. Hamilton, a native of Villa Rica, received his medical education at Emory University, graduating in the class of 1916. He had practiced medicine in Douglasville and the vicinity for the past 41 years, with the exception of two years when he served in the Army Medical Corps during World War I.

Dr. Hamilton was a member of the Methodist Church and the Carroll-Douglas-Haralson Medical Society.

Funeral services were held at the First Methodist Church of Douglasville, with burial in the Villa Rica Cemetery.

JOSEPH DEAN McELROY, Atlanta, died in a private hospital in Atlanta on April 26, 1956, after an illness of several months. He was 41 years old at the time of his death.

Dr. McElroy, a native Atlantan, graduated from Emory University and the Medical College of Georgia, class of 1941. He served in the U. S. Naval Reserve from 1942 to 1946, being released from active duty with the rank of lieutenant commander. He did postgraduate work at the U. S. Naval Medical Center, Bethesda, Md.; U. S. Naval Hospitals in Jacksonville, Fla., and Dublin, Ga., and at St. Elizabeth's Hospital, Washington, D. C. Dr. McElroy specialized in neuropsychiatry.

Dr. McElroy was a member of the American Psychiatric Association, Southern Psychiatric Association, and Georgia Psychiatry Association. He was formerly secretary

(Deaths)

of the Atlanta Society of Neurology and Psychiatry. He was a former instructor in psychiatry at the Emory University School of Medicine.

He had recently been appointed a member of the advisory committee for the Mental Hygiene Division of the Georgia Health Department. He was for two years chairman of the Mental Health Committee of the Fulton County Medical Society.

Funeral services were held on April 27 at Spring Hill, Atlanta, with burial in Arlington Cemetery in Sandy Springs. He was a member of Covenant Presbyterian Church.

Surviving Dr. McElroy are his wife, the former Miss Beth Morrison; daughter, Miss Frances Anne McElroy; his mother, Mrs. J. M. McElroy, and a sister, Miss Mary Ellen, McElroy, all of Atlanta.

ROBERT VINCENT MARTIN, Savannah, retired physician, died April 15, 1957, after a long illness. He was a former president of the Georgia Medical Society.

A native of Allendale, S. C., Dr. Martin began practice in Savannah in 1906 and retired in 1948 because of ill health. Dr. Martin was the first president and medical director of the Chatham-Savannah Tuberculosis Association, which he was instrumental in organizing about 30 years ago. He was a charter member of the Kiwanis Club and was recognized with an honorary membership in that organization when he retired from active practice.

Dr. Martin won international recognition for his work in the cure of meningitis and in 1914 was honored by the Italian Physio-Chemical Academy of Palermo, Italy, in this connection. He was graduated from the South Carolina Medical College in 1904 and interned at the Lying-In Hospital and New York State Hospital, New York City.

A communicant of St. John's Episcopal Church, he was a member of Landrum Lodge No. 48, Free and Accepted Masons. For a number of years he was chairman of the board of the old Savannah Hospital before it became the Warren A. Candler Hospital.

Surviving Dr. Martin are his wife, the former Miss Annie Dunwoody; a son, Mr. Robert V. Martin, Jr., Savannah; two daughters, Mrs. Donald B. Anderson, Evanston, Ill., and Mrs. Duke Lane of Fort Valley.

CLIFF MOORE, Lindale, died on April 26, 1957, following an illness of several months. He was 71 years old.

Dr. Moore was born in Montevallo, Ala., and was a graduate of the University of Alabama. He had practiced medicine in Lindale for 43 years. He was a member of the Floyd County Medical Society and was on the staff of McCall Hospital and Floyd Hospital.

Dr. Moore was also a member of the Shrine, Yaarab Temple of Atlanta; and Lindale Lodge No. 455, F. and A. M. He was a past commander of the McClain-Sealock American Legion Post.

Surviving him are his two sons, C. W. C. Moore and Cliff Moore, Jr., both practicing physicians in Rome; a brother, Carey Moore, Talladega, Ala., and three sisters, Miss Mary Sue Moore, Mrs. Joe Bailey, and Mrs. W. W. Randall, all of Birmingham, Ala.

Funeral services were held at the Lindale Methodist Church with burial in the family lot in East View Cemetery. Active pallbearers included John T. McCall, Tom H. Moss, and A. F. Routledge. Members of the Floyd County Medical Society formed an honorary escort.

AMOS C. SMITH, Elberton, died on March 29, 1957, after an illness of a week. He had been in declining health for several years.

Dr. Smith was a native of Elbert County and was in the active practice of medicine for 55 years prior to his retirement in 1950. He was the first physician in that section to specialize in x-ray work.

Dr. Smith is survived by his wife, Mrs. Janie Cleveland Smith; a daughter, Mrs. J. W. Amoss, Fairburn; two sons, Mr. Ben C. Smith, Elberton, and Mr. A. McRae Smith, Decatur.

LLOYD B. TAYLOR, Savannah, died on April 27, 1957, after a long illness. He was 79 years old at the time of his death.

Dr. Taylor graduated from the University of Tennessee in 1911 and followed his father and grandfather in the practice of medicine. He had been in practice in Savannah since 1912 and served as city physician for 20 years.

A veteran of the Spanish-American War, he later was medical officer of the Chatham Artillery from 1912 to 1915. He went to the

Mexican Border with the First Georgia Regiment, which later became the 118th Regiment. He was major and regimental surgeon of the 118th Field Artillery during both World Wars.

Dr. Taylor was a 32nd degree Mason and a former member of the Georgia Society of Colonial Wars. He was a communicant of St. John's Episcopal Church.

Surviving him are his wife, the former Miss Louise Meeks; and four daughters, Mrs. Richard Lynes and Mrs. William Hopkins, Jr. of Savannah; Mrs. Earl McCutchen, Athens; and Mrs. Fred Coenan, Chester Pa.

Graveside services were held in Bonaventure Cemetery, Savannah.

SOCIETIES

The annual meeting of the FIRST DISTRICT MEDICAL SOCIETY was held on April 17, 1957, at Statesboro. Newly elected officers are as follows: William G. Simmons, Sylva, president; Lee Howard, Jr., Savannah, president-elect; Randall C. Brown, Swainsboro, vice-president; and William H. Fulmer, Savannah, secretary-treasurer, guest speakers at the meeting included Hal M. Davison, Atlanta, the then president of the MAG; J. Willis Hurst, Atlanta, professor of medicine at Emory University School of Medicine who spoke on "Obesity Heart Disease"; and A. P. Richardson, Atlanta, dean of the Emory University School of Medicine.

The EIGHTH DISTRICT MEDICAL SOCIETY met at Jekyll Island on April 12, 1957. Stephen R. Ellis, co-chief of the department of anesthesiology, St. Joseph's Infirmary, Louisville, Ky., discussed "Obstetrical Anesthesia." George H. Harrell, dean of the University of Florida College of Medicine, Gainesville, talked on "Myxedema"; and a surgical panel discussed "Management of Traumatic Lesions in Children." The panelists were Harold Engler, John Fair, and Floyd Blevin, all of the Medical College of Georgia faculty. Dinner and dancing followed the meeting.

The NINTH DISTRICT MEDICAL SOCIETY met at the Cornelia Community House on April 17, 1957. The scientific session featured talks by Charles M. Henry, Cornelia—"Some Complications of Fractures of Femur"; Phillip Warga, Athens—"Afibrinogenemia"; clinicopathologi-

cal conferences presented by F. O. Garrison, Demorest, and Don Fahrback, Cleveland. Discussors included Hal M. Davison, Atlanta; David Henry Poer, Atlanta; Phillip Warga; Hamil Murray, Gainesville; and Charles M. Henry, Cornelia. A social hour at the home of Dr. and Mrs. George Nicholson in Cornelia and dinner at the Cornelia Community House followed the business session.

At the April meeting of the RICHMOND COUNTY MEDICAL SOCIETY in Augusta, John A. Wagner, associate professor of pathology and director of the Division of Neuropathology at the University of Maryland School of Medicine, spoke on "Pathological Manifestations of Certain Common of Important Neurological Entities."

PERSONALS

First District

FRANKLYN P. BOUSQUET, Savannah, has been elected to a two-year term on the Coordinating Council on Services to the Handicapped it was announced at the annual meeting held on April 23, 1957, in Savannah.

JOHN A. DUNCAN, Metter, has reopened the Nevil Clinic in Metter for the practice of general medicine and surgery. Dr. Duncan is a graduate of the University of Edinburgh (Scotland) and has been in the United States for only 11 years. He was for eight years medical director of the E. I. du Pont de Nemours plant near Augusta, after which he practiced privately for a short time in Glenwood.

CURTIS G. HAMES, Claxton, recently visited the L. S. U. School of Medicine in New Orleans.

PETER L. SCARDINO, Savannah, is a new member of the executive committee of the Southeastern Section of the American Urological Association. Dr. Scardino was elected to this post at the 21st annual meeting of the organization held in Atlanta in April.

Second District

No news received.

Third District

WALTER D. MARTIN, Dawson, was honored on his birthday with a

party given by the Terrell County Gray Lady unit of the American Red Cross. Invited to the surprise party were Dr. and Mrs. F. E. SIMS; Dr. and Mrs. R. R. Holt; Dr. and Mrs. CHARLES M. WARD; and Mr. and Mrs. W. R. Martin, of Shellman, parents of Dr. Martin; and Mrs. Kenneth Campbell and Mrs. Lamar Allen, members of his office staff. As chief of staff of Terrell County Hospital, Dr. Martin with Drs. Sims, Ward and Holt, give their full cooperation to the Gray Ladies' work and this was their way of expressing their appreciation.

ROBERT H. VAUGHAN, Columbus, spoke to the Muscogee Lions Club recently on the incidence of lung cancer among smokers and non-smokers. He quoted a pathologist as saying a smoker has a one-in-10 chance of developing lung cancer while a non-smoker has a one-in-275 chance of developing cancer. At the same meeting, BRUCE NEWSOM, Columbus, explained the function of the local cancer clinic. He said the clinic for indigent patients is financed by the state and federal governments. There are seven physicians and one dentist who give their time free for five hours a week.

LUTHER H. WOLFF, Columbus, spoke to local Rotarians recently on "The Value of the Hospital in Our Community." He was introduced by JAMES ELKINS, April program chairman of the organization. Dr. Wolff is president of the Kiwanis Club of Columbus.

Fourth District

ERNEST A. DUNBAR, JR., and ALBERT L. STONE, Forest Park, have opened their new offices at 1271 Main Street, Forest Park. Open house was held at the office on Sunday, May 4, with everyone in the community invited.

BEN H. JENKINS, Newnan, was the feature speaker at the annual Memorial Day exercises held in Newnan on April 26. The program was presented at the Municipal Auditorium, and at its conclusion the traditional march to Oak Hill Cemetery was made by students of the seventh and eighth grades, where wreaths were placed on the graves of Confederate soldiers.

GOODWIN G. TUCK, Covington, has been named chief of staff

of the Newton County Hospital. Dr. Tuck is a native of Covington and a graduate of the University of Georgia and the Medical College of Georgia. He interned at Charity Hospital in New Orleans, La., and served his residency at Charity Hospital in Lafayette, La. He entered private practice in Covington in 1953.

Fifth District

RICHARD W. BLUMBERG and ABNER GOLDEN, Atlanta, have been elected honorary members of the Emory University Chapter of Alpha Omega Alpha, national honorary medical fraternity. They and the other new members, all members of the junior class at Emory University School of Medicine, were honored at the fraternity's annual banquet on "Student Research Day," April 24, 1957.

WINSTON E. BURDINE, Atlanta, addressed the members of the Xi Iota and Alpha Psi chapters of Beta Sigma Phi sorority at a meeting held at Coleman Library, LaGrange, in April. The title of Dr. Burdine's talk was "One of Our Greatest Battles"; he related a brief history of mental illnesses, discussed their two major suspected causes—chemical and environmental; and stressed the need for a bigger Georgia mental health fund.

HAROLD A. FERRIS, Atlanta, has been elected president of the Diabetes Association of Atlanta. Other officers elected in April to serve with Dr. Ferris are as follows: T. LUTHER BYRD, vice-president; EDWIN C. EVANS, secretary-treasurer; WILLIAM L. PAULLIN, JR., chairman of the board; and WALTER L. BLOOM, program director (re-elected).

Among the speakers at the annual meeting of the Atlanta Tuberculosis Association held in April were JAMES F. HACKNEY, THOMAS O. VINSON, CLARA BARRETT, and CHARLES A. LeMAISTRE, all of Atlanta. Last year's officers of the organization have been re-elected; they are Mr. Sam Phillips McKenzie, president; JOSEPH S. CRUISE, vice-president; and Mr. Charles E. Shepard, treasurer. W. MERCER MONCRIEF is a newly installed member of the board of directors.

VIRGINIA McNAMARA, Atlanta, a native of Pineview, has been

appointed director of the division of school health. Georgia Department of Health, Atlanta. Dr. McNamara is a graduate of Agnes Scott College, the Medical College of Georgia, and Washington University. She has done postgraduate work at the University of Rochester and the University of Vienna. She returns to Georgia from a position in California.

ARTHUR J. MERRILL, Atlanta, addressed the meeting of the Southeastern Section of the American Urological Association held in Atlanta in April. He described the use of sodium resin in treating patients with kidney shutdown. He said that in the past four years, the drug had cut down by nine-tenths the necessity of using the artificial kidney at Grady Memorial Hospital where 85 patients have been treated with sodium resin.

WILLIAM E. GOODYEAR, Atlanta, has been named an alternate to the executive committee of the Southeastern Section of the American Urological Association.

Sixth District

The four physicians who formerly composed the medical staff of the Richard Binion Clinic in Milledgeville have moved into their newly constructed office building on Cobb Street in West End, Milledgeville. The building is known as the Professional Center, and its physician-occupants are O. C. WOODS, CHARLES B. FULGHUM, E. Y. WALKER, and HOWARD CARY.

Seventh District

A panel discussion by the physician members of the Calhoun Rotary Club was the feature of a recent meeting of the club. J. E. BILLINGS was moderator; panel members included CHARLES K. RICHARDS, W. D. HALL, and R. D. WALTER. Club members submitted questions for the panel to discuss.

Three Battey State Hospital doctors participated in the program of the National Tuberculosis Association convention in Kansas City, Mo., May 6-9: RAYMOND F. CORPE, Rome, spoke on "The Fate of the 'Open Negative' Patient" and "Therapeutic Efficiency of Pyrazinamide." JOHN H. GROSS spoke on "Georgia's Experience with Compulsory Isolation of Uncooperative Tubercu-

losis Patients"; and HORACE CROWE participated in a panel discussion on the atypical type of tuberculosis.

THOMAS E. HAMILTON, formerly of Marietta, has opened an office for the practice of medicine in Cartersville on East Main Street. Dr. Hamilton is a graduate of the Medical College of Georgia and interned at Columbus City Hospital. For some time he has been on the medical staff of Lockheed Aircraft Corporation's Marietta plant. Dr. Hamilton is a native of Winder and a brother of VIRGINIA HAMILTON MALEY, Cartersville, president of the Bartow County Medical Society.

CLIFF MOORE, CAREY MOORE, HARLAN STARR, and A. V. GAFFORD, all of Rome, formed a panel for the discussion of smoking and lung cancer at a recent meeting of the Rome Exchange Club. Two other doctors who are members of the club, C. J. SAPP and R. E. ANDREWS, were unable to attend. The discussion followed the presentation of a film, "The Warning Signal," which emphasizes the importance of chest x-rays being made every six months for all men over 45 years of age.

ROBERT F. NORTON, Rome, is the 1957 recipient of Floyd County's "Outstanding Civic Service Award." Some 500 members of the Chamber of Commerce of Rome and Floyd County attended the banquet at which the presentation was made. The award is given each year to the Chamber member who is outstanding in his contributions toward the health and welfare of the community. Dr. Norton is a native of Rome, attended Rome elementary schools and Darlington before graduating from Davidson College and George Washington University. He has been in general practice in Rome for 19 years, exclusive of the time spent in the U. S. Navy in World War II. Dr. Norton is a member of the Rome Board of Education; Darlington School Board of Trustees, Sunday School teacher at the First Presbyterian Church, past president and member of the Rome Rotary Club, and former member of the Rome-Floyd Health Board.

Eighth District

Five Brunswick physicians led panel discussions on the subject of

cancer education at a meeting sponsored by the Woman's Club of Brunswick in April. BERT MALONE discussed radium and x-ray treatment of cancer; ROY F. THAGARD, cancer in children; E. R. JENNINGS, surgery; JOHN A. HIGHTOWER, chemical and radioactive treatment; and JOSEPH B. MERCER, family diagnosis and treatment.

W. D. MIXSON, Waycross, celebrated his 87th birthday anniversary on April 18, 1957. Dr. and Mrs. MIXSON were at home to their friends during the day, and among those who called were members of the Board of Directors of the First Federal Savings and Loan Association, of which Dr. Mixson is president. A birthday cake, gift of the directors, was served with refreshments.

W. W. PAYNE, Brunswick, attended the meeting of the Southeastern Section of the American Urological Association held in April.

Ninth District

STEWART D. BROWN, JR., Royston, announced the official opening of the Stewart D. Brown M. D. Memorial Clinic on Franklin Springs Street in Royston. The new building is next to the old Brown's Hospital building, which is in the process of being dismantled to make room for a parking lot. The building is named in memory of Dr. Brown Jr.'s father, and open house was held on the anniversary of his birth, April 18th.

Dr. and Mrs. HARRY HUTCHINS, Buford, spent several days in St. Louis, Mo., in March where Dr. Hutchins attended the meeting of the American Academy of General Practice.

H. H. McNEELEY, Toccoa, attended the annual meeting of the AAGP in St. Louis in March.

Tenth District

In April, the Orlin K. Fletcher Post 3200, Veterans of Foreign Wars, honored three Augusta physicians in a special program entitled, "Gentlemen of the Three Faiths." the three are WILLIAM D. JENNINGS, a protestant; W. WHATLEY BATTEY, a Roman Catholic; and D. MARION SILVER, a Jew. Their combined years of medical service total 160.

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COVER

The cover photo illustrates one type of diaphragmatic hernia. See page 322.

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MEDICINE'S PLACE IN SOCIETY

W. BRUCE SCHAEFER, M.D., Toccoa, Georgia

***The incoming president addressed the members
of the House of Delegates at the 1957
Annual Session in Savannah***

IT IS WITH DEEP APPRECIATION and humility that I accept the presidency of the Medical Association of Georgia, which, I believe, is going to set a national pattern in service to the people. The establishment of this pattern has not and will not be an overnight job. We have been digging in the vineyard in earnest for some years now. Doctors by training and by nature move with caution and prudence.

I pledge you my best efforts to meet the challenge you have laid down for me. I am following men whose records provide a stimulus for the job ahead. I intend to borrow from their best works and ask their advice when it will help to advance our worthwhile projects and programs. For every man is a composite of the good, or bad, of those whose lives touch his own.

This is not a day for boasting. Instead, it is one on which we of the medical profession accept a challenge. That challenge is one of leadership. Who knows better the social and economic problems relating to medicine than the medical profession itself? Then it is our moral and social obligation to aid in

bringing about the indicated adjustments and improvements that will keep medicine in its rightful position in modern society.

Doctors are entitled to remuneration for their services, yet any man endowed with the talent for being a true physician has no right to commercialize that talent. By the same token, the person who is able to pay has no right to free services. There is no method by which the value of good medical service can be appraised.

Some standard of fees is recognized as essential, but to maintain a standard of fees which is prohibitive to low income groups is neither morally nor economically just. The quality of service should be the same for all. The cost of that service should be in relation to the advice rendered, the treatment given, and the patient's ability to pay. Such practice is not only sound policy but a basic requirement of our Code of Ethics. To do one whit less is a gross violation of the Hippocratic Oath.

May I say here that we are well aware of the fact that there is a sufficient number of physicians in this state, and in the nation, who charge fees excessive

enough to cause the public to blame the entire profession. But that is no reason why the medical profession should tolerate its small percentage of fee gougers.

These men are being dealt with through grievance committees. Most Georgia societies have such committees. Their chief function is to provide a means of redress or adjustment when there is a justified cause for complaint. We invite the public to use these committees if and when the occasion arises.

In this day of inflation, many families are forced to budget their earnings—and so are many doctors. It is necessary and only proper that doctors assist their patients in this regard. The success of any practice demands that every doctor discuss with his patients the social and economic problems incident to illness.

If I had but one prayer for present and future medicine, it would be that those who teach, and those who are taught, should never allow the influence of the economic side to enter into the plan of treatment—indigent or millionaire.

We need to explain to the public, carefully and fairly, the cost of medical care. The U. S. Bureau of Labor Statistics reveals that each year the American people spend about four cents of each dollar for doctors' services, about five cents for cosmetics, about six cents for tobacco and 13 cents for whiskey, wine and beer. This is no temperance lecture; it is simply a comparison of the expenditures that nick into the American family's budget dollar.

You and I hear complaints every day about the cost of drugs. Of course these drugs are higher than the aspirin, calomel, and castor oil of another era of medical practice. But they actually are cheaper, if the patient would just compare his losses in time from work, the much shorter duration of the illness—and consider the fact that modern drugs save many lives, whereas in 1900 they only relieved pain.

Unfortunately, many people wait to worry about the unexpected illnesses, or long confinement, *after* they have occurred. Yet, a combination hospital-surgical-obstetrical insurance policy can be purchased at a cost well within the reach of every man who can afford to pay anything at all to protect his family's health—and its budget. Man has the same moral obligation to protect himself and his family against unforeseen illness as he has to protect himself against fire, theft, storms and, finally—against death.

Since the Medical Association of Georgia was organized 105 years ago, Georgia doctors have been treating indigent patients at no cost. The average Georgia physician gives 10 to 25 per cent of his time free of any cost whatever to the patient,

the city or county, or the state. We challenge any other profession to equal or surpass that record. We shall continue to live up this pledge in the Hippocratic Oath. So, many of us are interested in a legislative resolution proposing that the state and its counties, on a fair matching basis, pay the hospital bills of the truly indigent—with members of our Association providing treatment free for the hospitalized indigent. A survey has been made to determine the over-all needs for such a plan. A report has been made to the Governor. When the next General Assembly meets, the medical profession will be asked to take a definite stand. The cost of indigent care in sickness now rests upon doctors, churches, labor and civic groups, voluntary and state health agencies, and generous and compassionate individuals. None of the so-called national health programs provided one penny for care of the hospitalized indigent. If we believe that charity begins at home, here is an opportunity to prove it. Here is a chance to save lives, to restore men and women to economic production, and to further advance our standards of health in Georgia.

Several years ago we fought national legislation variously labeled "Socialized Medicine," "Government Medicine," and "Political Medicine." We won that battle. One reason for our victory was that the public became convinced that such a scheme would indeed deprive them of their "freedom of choice" of a physician.

Today in our state many employed persons are denied this privilege by certain industries, if there is an industrial benefit involved. Why not have a panel of qualified physicians set up and made public, and then let the worker and his family choose one, or two, from this panel? Why must he *have* to accept the "company doctor"? I am declaring this is an injustice, although I myself am the "company doctor" in some instances. But I hope I am honest enough to admit that there are probably some workers for these companies who might prefer someone else. If we fought political medicine on the main ground that it denied freedom of choice throughout the nation—then why don't we practice what we preach right here at home, in the field of industrial medicine, where thousands of people consume medical services? I advocate such a bill in the next legislature to equalize this discrepancy, and I appeal to you to back it—morally, actively, and to the end of the session.

Going further in legislation, we now have a law in Georgia that industry cannot employ the handicapped without being penalized. Georgia is fifth in the nation on rehabilitation and thirty-eighth on employing the handicapped. This great discrepancy should be lessened. Our rehabilitated people should

New Members of the Medical Association of Georgia

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Edward L. Groover	Medical Arts Bldg., Marietta	Active	Cobb
Roy Thurman Ward, Jr.	Watkinsville	Active	C. W. Long
Robert F. Eaves, Jr.	3711 3rd Ave., Tucker	Active	DeKalb
Frank Traill Fralick	224 Central Ave., SW, Atlanta 3	Active	Fulton
James B. Minor	384 Peachtree St., NE, Atlanta 8	Active	Fulton
J. Anthony Heffernan, Jr.	14 W. Jones St., Savannah	Active	Ga. Med.
Andre Peter Phillips	323 E. Jones St., Savannah	Active	Ga. Med.
Donald C. Fahrback	Cleveland	Active	Habersham
George Everett Donaghy	St. Francis Hospital, Columbus	Active	Muscogee
Dan Callahan	Warner Robins Clinic, Warner Robins	Active	Peach Belt
Robert A. Collins, Jr.	142 South Jackson St., Americus	Active	Sumter
Ladislao K. Wallerstein	Screven & Culpepper St., Quitman	Active	ThomasBrooks

MEDICINE'S PLACE IN SOCIETY CONTINUED

be encouraged to carry their share in our economy and leave the welfare roles. I advocate a bill that will allow industry to employ the handicapped with a waiver on their present disabilities so that the employers and their insurance companies would not be penalized in case of a disaster. I earnestly request your support of such a bill.

As for the corporate practice of medicine, I merely wish to state that in Georgia it is illegal, and in American medicine it is unethical.

Many hard working doctors in this state are also hard working citizens. We fervently hope that many more will become active in civic affairs—so long as this does not deprive anyone of prompt medical care. The scientific progress of medicine has been tremendous in the past quarter century, but this progress has caused many physicians to withdraw into a scientific shell and take little part in public life. Perhaps that is one reason that modern medicine has not earned for itself the place it deserves in society. It really has a most important place in society; it simply has not asserted its right to that place.

What I am saying today may not be 100 per cent popular. Those who feel that everything is all right, or that it is as right as it should be, certainly are going to disagree with me. What I am really trying to say is that if we do not constantly strive for improvement, there can be no progress, only stagnation and death. To quote a great statesman: "If we do not look backward, we never look forward."

Now in conclusion—please let me get down to the core of the matter that is closest to my own heart. It is sad—and little perverse—that many professions

rob themselves of coveted public confidence by internal strife. If we constantly criticize each other, personally or professionally—how can we expect the public to have full confidence in us as a group?

This is not to say that doctors should not disagree. We all know that without scientific disagreement, open and honest, there would never be any medical progress. Suppose Crawford Long had *agreed* that there was no chemical that would ease the pain of major surgery? Suppose Fleming had *agreed* that the soil did not contain elements that could produce a life-saving antibiotic, or Semmelweis had agreed that sepsis played no important part in post-partum mortality. We must always encourage such stimulating and productive disagreements.

But here we must stop. Carping criticism of another physician, whether it is uttered to a patient or in the executive session of a committee meeting, inevitably weakens the whole structure of the fellowship which is our rich heritage. The people are better informed on medical care than many think. They know the difference between good medical practice and quackery. So, if we really believe in and cherish that fellowship that we need so badly today—I humbly appeal to you to live and practice in such a fellowship. Let us develop a faith so absolute that we shall all seem as one man of medicine—fair, compassionate and competent. May I leave you, my fellows in Georgia medicine, with this challenging quotation:

"Be Loyal to the Royal That is Within Thyself." For the medical profession is much greater than any one or all of its individuals.

***A comprehensive review of the several types
of diaphragmatic hernia with discussion of advances
in diagnosis and treatment***

DIAPHRAGMATIC HERNIA

CHARLES H. WATT, JR., M.D., Thomasville, Georgia

THE CLINICAL SIGNIFICANCE of the diaphragmatic hernia, especially the hiatal type, has become more apparent in recent years. We are aware that the diaphragmatic hernia can produce symptoms found in many other conditions of the chest and upper abdomen.

Ambrose Pare in 1575 was evidently the first to describe the diaphragmatic hernia. He reported two cases of traumatic origin. In 1656 Riverius recorded the first case of congenital hernia. This was described from an autopsy. This condition remained a medical curiosity for approximately three centuries until Akerland's comprehensive report in 1926.

In 1940 Guthrie and Jones showed the true clinical significance of these hernias and pointed out that often a small hernia may cause more symptoms than a large one.

It has been reported that approximately nine per cent of patients undergoing radiological examination of the upper gastro-intestinal tract have a demonstrable hiatal hernia. Many feel that this depends on the time and interest of the radiologist. We feel that no roentgenogram is complete unless the patient's head has been lowered and every attempt made to demonstrate a hiatal hernia.

Classification

The classification of hernias listed below is ad-

justed from a combination of Allison's and Harrington's classifications.

NON-TRAUMATIC

- a. Congenital
 - Pleuroperitoneal (Foramen of Bochdalek)
 - Anterior substernal (Foramen of Morgagni)
 - Short esophagus
 - Gaps in diaphragm or absence of hemidiaphragm
- b. Acquired at esophageal hiatus
 - Paraesophageal
 - Sliding

TRAUMATIC

- a. Direct injury
- b. Indirect injury
- c. Result of inflammatory necrosis

Pleuroperitoneal (Foramen of Bochdalek)

Hernias through this opening are more commonly found on the left side due to the location of the liver on the right. They occur laterally and posteriorly in the muscular part of the diaphragm, not far from the ribs. There is no peritoneal sac. It may produce symptoms of obstruction and is handled better through an abdominal approach. They are more frequently found in children.

Anterior substernal (Foramen of Morgagni)

Herniation through the parasternal hiatus or foramen of Morgagni is a type of congenital hernia usually seen in the adult. Such hernias are fairly rare. There is a true sac in 50 per cent of the cases. Symptoms usually result from herniation of the abdominal viscera. This is more commonly seen on the right side. We believe that the abdominal approach is preferable.

Short Esophagus

Congenitally short esophagus (thoracic stomach)

—This is an extremely rare condition, and we will not dwell on it other than to say that Kirklin and Hodgson call this the only real “thoracic stomach.” The patient may have symptoms of a sliding hernia, even from birth.

Gaps in the diaphragm or absence of the hemidiaphragm—These usually occur in early infancy requiring immediate surgery in order to prevent death. The diagnosis should be made early. Cyanosis and severe circulatory and respiratory distress should make one suspicious of the diagnosis. Sometimes it is difficult to repair this defect. The abdominal cavity frequently will not accommodate the intestines, and it may be necessary for the operator to suture only the abdominal skin, later repairing the incisional hernia.

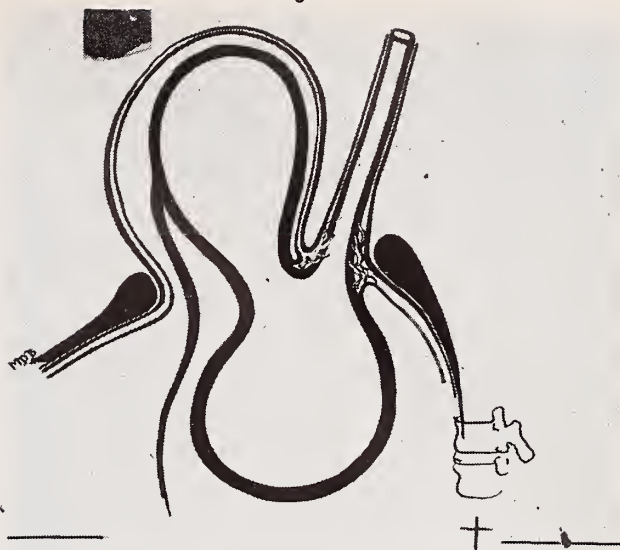
Acquired at Esophageal Hiatus

Paraesophageal—The unique feature of this type of hiatal hernia is the fact that the cardia lies below the diaphragm as opposed to the sliding type. The esophagus keeps its normal length and position, and the hernia rises into the mediastinum beside it. When the hernia enlarges, the herniated portion of the stomach rotates in such a way that the greater curvature moves upward so that the stomach has the appearance of being “upside down.” Frequently the pylorus and cardia are seen on x-ray to be at the same level. This type is less common than the sliding, occurring in about seven per cent of all diaphragmatic hernias. We do not get a reflux of gastric juices, as the esophagus still has its acute angulation in relation to the stomach. The sac of the paraesophageal hernia lies anterior to the esophagus in practically all instances, but Allison did report one case in which the sac lay behind the esophagus (Figure 1). These cases, we feel, are best treated by the transthoracic approach.

Sliding Hiatal Hernia

This type is by far the most common of all diaphragmatic hernias, occurring in between 80 and 90 per cent of the cases. The cardia and the stomach are found above the diaphragm, and the esophagus

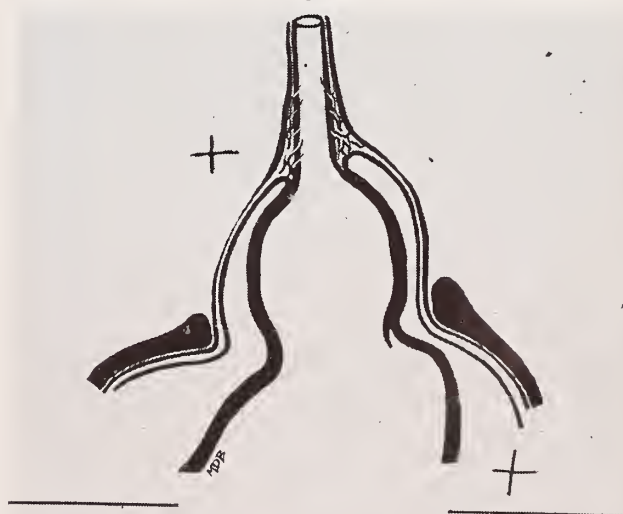
Figure 1



The anterior wall of the stomach extends above the diaphragm and into the sac. Note the cardia below the diaphragm. This is a paraesophageal hernia. (After Allison.)

gives the impression of being shortened. Some people call this the short esophagus, but it should not be mistaken for the true congenital short esophagus. These patients complain of upper abdominal pain and fullness after meals. They may have substernal pain along with palpitation, dyspnea, and sometimes weakness secondary to an anemia which may be due to blood loss from a secondary ulceration of the esophagus. The cardia is located above the diaphragm. It is very easy for gastric contents to pass into the esophagus causing esophagitis, ulceration, and later perhaps stricture formation. These patients complain more of a heart burn. They may speak of dryness and heat in the throat and a hot pain in the side of the neck. Nausea is not too common in this type of hernia. Vomiting is not uncommon, but it is usually self induced. The symptoms must

Figure 2



The cardia is now located above the diaphragm along with both sides of the stomach. This is a sliding hernia. (After Allison.)

be differentiated from lesions in the epigastrium such as gallbladder disease, duodenal ulcer, chronic recurrent pancreatitis, and other conditions. The differentiation between the symptoms of the sliding hernia and those of angina pectoris can be extremely difficult. The pain in both conditions may be substernal, and it may radiate into the left shoulder and down the arm into the ring and little fingers. *Treatment:* Most patients can be treated medically if the hernia is not too large and if there are no serious complications or symptoms. Harrington believes that if a third or more of the stomach is involved, surgery is indicated to prevent possible incarceration. If medical treatment fails, then surgery should be performed. Allison urges surgery in sliding hernias at the first sign of esophagitis, for stenosis occurs if it is neglected. The results of surgical treatment are poor after stenosis. In recent years, since the thoracic approach has become a less formidable procedure, the surgical repair of diaphragmatic hernias has been extremely successful. Interruption of the left phrenic nerve is a procedure that will sometimes alleviate symptoms. It is not a cure, but it may be a life saving measure, especially in an elderly patient in whom surgery is considered a great risk.

Traumatic Hernia

Harrington, who has had a great deal of experience with the traumatic hernia, uses the following

classifications: (1) direct injury, (2) indirect injury, and (3) inflammatory necrosis. This type of hernia is more frequently found in the male. Stab wounds and gunshot wounds are good examples of direct injuries. With the increase of automobile accidents, the crushing type of injury may be an indirect cause. The subdiaphragmatic abscess is usually the cause of inflammatory necrosis. In Harrington's series of 67 cases, 65 occurred on the left side. The liver protects the right diaphragm very well. The traumatic hernia is very dangerous because of the possibility of intestinal obstruction. When they herniate through the esophageal hiatus they usually have a sac; the others do not. When one is exploring the abdomen for an intestinal obstruction he must always keep in mind this possibility, even though he may not know of the previous injury. It is also not uncommon to find symptoms developing several weeks following a stab wound, at which time a loop of bowel should be suspected as having been pinched off. It is extremely important in taking a history to ask about previous injury. These cases are easily repaired, and we feel, should be done through a transthoracic approach.

Illustrative Cases

Case 1. Paraesophageal Hernia. This was the case of a 30-year-old white male who came in complaining of fullness and burning in the epigastrium of six to seven years' duration. There was no history

Figure 3



Note that one-third of the stomach is located above the diaphragm. Pre-operative.

Figure 4



Same case as Figure 3. Post-operative. Note silver clip on diaphragm. All of stomach beneath.

Figure 5



Sliding hiatal hernia. Pre-operative. This illustrates Case 2, as does Figure 6.

Figure 6



Same case as Figure 5. Post-operative. Entire stomach beneath diaphragm.

of injury. There was some vomiting which occurred one hour after eating. He had been tried for several months on a rigid medical regimen. Recently he had begun regurgitating every meal. Every time he lay down he experienced a full feeling in his epigastrium which was relieved by sitting and standing. There was no hematemesis or melena. Burning in his epigastrium was common.

Figures 3 and 4 show about one-fourth of the stomach above the diaphragm with the paraesophageal type. The hernia was repaired transthoracically. The patient has done well post-operatively.

Case 2. Sliding Hiatal Hernia. This was a 72-year-old white female who complained chiefly of nausea and vomiting with epigastric pain. She had had her left phrenic nerve crushed four years previously. This had given her relief for two years, but since then the symptoms had become very severe, with vomiting and a "lump" in the epigastrium relieved by soda and change in position. She was unable to eat when lying down. She had "gas on her stomach" occasionally. Pain radiated also to the suprasternal notch. X-rays showed about a fourth of the stomach located above the diaphragm, and a sliding type of hernia was demonstrated. A left thoracotomy was performed using an Allison type of repair with good results. (See Figures 5 and 6.)

Case 3. Sliding Hiatal Hernia. This was the case of a 74-year-old white female. For three months she

had intermittent nausea and vomiting with epigastric pain. She was extremely weak and at times had melena. During the last two weeks she had had almost constant vomiting. X-rays showed that 50 per cent of the stomach was located above the diaphragm, as seen in Figure 7 and 8. After improving her condition with blood and electrolytes, a left thoracotomy was performed using the Allison type of repair with excellent results.

Case 4. Parasternal Hernia (Foramen of Morgagni). This case is one of a 65-year-old white male who stated that as a child he was kicked in the sternum by a mule. Four years before admission he was gored by a bull in the lower part of the sternum. We do not know whether these two episodes are of significance or not. For 10 to 15 years he had suffered right upper quadrant pain which had become much worse in the previous six months. He had flatulence along with pain in the right upper quadrant, the left side of the neck, and in the region of the mandible. There was no dyspnea, melena, or hematemesis. On physical examination, he had a marked kyphosis with an increased AP diameter of the chest. Blood pressure was 170/88. He was moderately obese. He was treated on a medical management with an attempt to lose weight for six months. The pain in his epigastrium became so severe that he demanded an operation. His pain became worse on lying down. Films as seen in Figures 9 and 10 show a

shadow in the anterior mediastinum which was diagnosed as a parasternal hernia following the in-

Figure 7



Sliding Hiatal Hernia. Fifty per cent of stomach above diaphragm. Pre-operatively.

Figure 8



Same as Figure 7. Post-operatively.

jection of air in the peritoneal cavity, as described by Clay and Hanlon. This hernia was repaired through an upper abdominal incision. The hernia contained a large amount of omentum. The patient died of a pulmonary embolus while preparing to go home.

Case 5. Traumatic (Indirect) Hernia. This was a 59-year-old white male who gave a history of a severe injury from an automobile accident two and one half years before admission. He complained of a gurgling in the left side of his chest, with slight shortness of breath, but his symptoms were not too severe. Because of the x-ray findings showing the stomach above the diaphragm and because of the possibility of an obstruction, a left thoracotomy was performed. There was no sac. The laceration was located in the center of the left diaphragm. The defect measured four and one half by three and a half inches in size. About three-fourths of the stomach was present above the diaphragm, as was about four and a half inches of small intestine along with part of the left lobe of the liver, two feet of transverse colon, and a large amount of omentum. There were a great many adhesions around the defect in the diaphragm. These were all freed and returned to the peritoneal cavity, and the diaphragm closed with interrupted silk sutures. The patient did extremely well and has had no symptoms since. (See Figures 11 and 12.)

Figure 9



Parasternal Hernia. Note air in subdiaphragmatic space and air in hernia above diaphragm. Seen also in lateral view in Figure 10 in anterior mediastinum.

Case 6. Absence of the Hemidiaphragm. This was the case of a five-year-old white female who complained of weakness, dyspnea, anorexia, and frequent vomiting. There was no history of pain. She had had two episodes of "pneumonia." Physical examination showed a poorly nourished child who was extremely fretful. There was no clubbing. She had a to-and-fro murmur of the heart over the right second interspace. The heart was enlarged to the right. The liver was not enlarged. Fluoroscopy showed mostly right ventricular enlargement. There was a small aortic shadow. Electrocardiogram revealed a dextrocardia. It was thought to be an absence of a hemidiaphragm, but the patient's parents refused surgery. (See Figures 13 and 14.)

Discussion

In general all types of diaphragmatic hernias containing the colon or small bowel should be repaired surgically, and all traumatic hernias should be repaired surgically. We believe that if a third or more of the stomach is involved, surgery is indicated to prevent possible incarceration. Another indication frequently is the failure of medical treatment. A rigid regimen should be tried first. The majority of hiatal hernias respond to medical management. This includes dietary measures, antacids, antispasmodics, weight reduction, omission of corsets, avoidance of strenuous exercise after meals, and sleeping with the

head of the bed elevated. Allison stresses surgery in a sliding hernia when the first sign of esophagitis

Figure 11



Traumatic (indirect) hernia. Pre-operative. Note abdominal contents above diaphragm.

Figure 10



The shadow in the anterior mediastinum diagnosed as parasternal hernia.

Figure 12



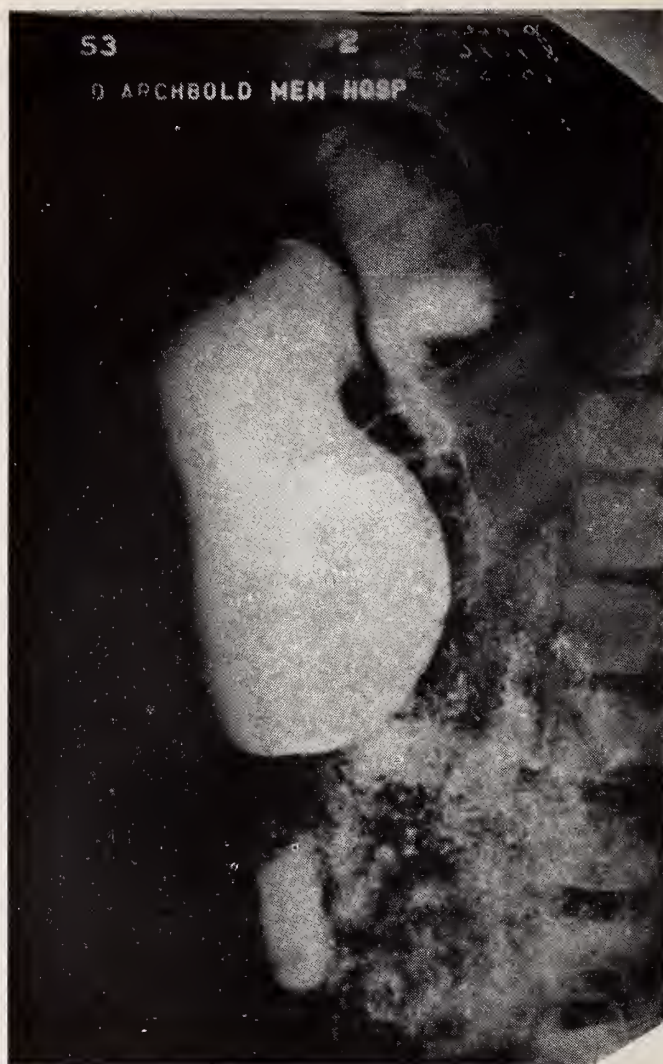
Same as Figure 11. Post-operative. Stomach below diaphragm.

Figure 13



Absence of hemidiaphragm. Shows the stomach, small and large bowel above the diaphragm in a five-year-old child.

Figure 14



appears so as to prevent a stenosis. We believe that in repairing the sliding hernia it is extremely important to use the Allison type of repair. He feels that it is more important to restore the physiological function of the cardia than to obtain a perfect anatomical result. In order to obtain this, it is necessary to repair the right crus of the diaphragm so that it functions normally.

Interruption of the left phrenic nerve is the procedure that is sometimes helpful in very elderly patients. This is not a cure usually, but may be life-saving, if it is not feasible to do major surgery.

Conclusion

The diaphragmatic hernia is much more common than we often realize. We must include it in our differential diagnosis in seeing patients with epigastric or anterior chest pain with or without nausea or vomiting. In recent years, since the thoracic approach has become a much less formidable procedure, the surgical treatment of diaphragmatic hernias has been very successful. Mortality and morbidity are low and recurrences are infrequent.

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PERFORATION OF INTRAVENTRICULAR SEPTUM DUE TO MYOCARDIAL INFARCTION

***Eight new cases are reported in which the diagnosis
was made during life and proven at autopsy.***

***Predictability, differential diagnosis, treatment,
and prognosis are discussed.***

RUPTURE OF THE intraventricular septum due to myocardial infarction is an uncommon but not rare occurrence. The purpose of this report is two-fold: first, to add to the literature eight cases diagnosed during life and proven at autopsy; and second, to attempt to sum up the predictability, treatment, and prognosis of this complication of myocardial infarction as found in the literature.

Cases

The data on eight patients diagnosed during life and proven by autopsy are tabulated in Figure 1. All of our patients developed a systolic murmur maximal in the third and fourth left intercostal spaces within eight days after their first episode of myocardial infarction. Fifty per cent showed an accompanying thrill. Two were seen within a few hours after clinical infarction occurred, and in these a murmur was present. It seems likely that each had actually suffered a silent infarction one or several days before rupture, and that the recent episode of pain actually represented the time of rupture. Six were given anticoagulants, but only four were considered to be in therapeutic ranges. Seven of eight were said to have had previous hypertension, but only four were hypertensive just prior to septal rupture.

Discussion

Predictability of ventricular septal rupture following myocardial infarction in the individual case is

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unreliable. Surveys of large numbers of autopsied cases show that interventricular septal rupture occurs in about two per cent of deaths due to acute myocardial infarction.¹² In this respect, it is interesting to note that even moderate-sized ventricular septal ruptures have been overlooked during the performance of routine autopsy studies. All clotted blood must be carefully removed from the septal wall since the small and medium-sized perforations may be totally occluded by post-mortem thrombi and thus escape detection. At times, small ruptures may be overlooked even with close and careful visual examination. These defects can be revealed by filling one ventricle with dye solution and observing its appearance in the opposite ventricular cavity. These procedures should be carried out in all patients dying of myocardial infarction, since septal rupture has been reported in the absence of the usual systolic murmur or other suggestive physical signs.

The appearance of a systolic murmur, heard with maximum intensity in the third and fourth left intercostal spaces adjacent to the sternum, in a patient suffering from a recent myocardial infarction, should bring to mind the possibility of intraventricular septal rupture. The differential diagnosis includes rupture of a papillary muscle or chorda tendinea and acquired mitral insufficiency due to left ventricular dilation. Differentiation by clinical means is not always easy, but a clue is contained in the position and character of the murmur. Rupture of a

papillary muscle usually causes a murmur of lower pitch and lesser intensity, which is heard at or near the apex and which may be either systolic or diastolic in time.² These patients rapidly develop severe left heart failure and almost invariably die within 48 hours. Rupture of a chorda tendinea produces a musical systolic murmur best heard at the apex, but this is rarely reported as being due to myocardial infarction.² Acquired mitral insufficiency due to left ventricular dilatation may appear quickly; it produces a systolic murmur loudest at the apex, which may be transmitted toward the axilla.

Many attempts have been made to depict the likely candidate for septal rupture, but review of the available literature at this time gives few clues and no direct indications.³²

Edmondson was the first to implicate systemic hypertension persisting after infarction and before rupture as a causative agent.¹² His views have been subscribed to by many subsequent authors.³² Edmondson's original series contained 13 cases of septal rupture, six of which had an "average blood pressure of 160/100 or over." Using similar criteria, and realizing the fallibility of the method, we have found in the available literature 54 cases which give direct information concerning blood pressure.* Of these, 28 have pressures varying from 125/100 to 200/140.** No case was included in this number if the diagnosis of septal rupture was present on admission, unless hypertension was still present. To be sure, this represents a small number of cases, but it demonstrates that rupture occurs as frequently in the hearts of the non-hypertensives as in hypertensives. In reviewing the literature, it was interesting to note that only rare cases of aortic stenosis, a lesion causing high intraventricular pressure, were reported with septal rupture and myocardial infarction. Neither Kumpie¹⁷ nor Bergeron⁴ mention rupture in any of their cases of aortic stenosis, although together they report a total of 33 healed and recent myocardial infarctions in autopsied cases of aortic stenosis.

The majority of cases of septal rupture following myocardial infarction fall in the age group of 60 or over. Of 67 cases in which sex was mentioned, and adding our own eight cases, there were 42 males and 33 females.*** Large series of myocardial infarctions show a three-to-one predominance of males in this age group.¹⁴ In these same series 56 per cent of females have hypertension, while only 27 per cent of males are so afflicted. There are approxi-

mately equal numbers of septal ruptures occurring in both sexes at this age, with a three-male-to-one-female discrepancy in actual numbers of infarctions. This fact, in addition to the prevalence of hypertension in females with myocardial infarction, would tend to lend some credence to the thought that septal rupture is somewhat more common in the presence of hypertension and in the female sex.

Of all possible contributory causes of intraventricular septal rupture after myocardial infarction, the most difficult to evaluate by reviewing the literature is the role of physical activity. We do not feel that the available material justifies any statement in this regard. Of our own eight cases, four were at bed rest at the time of the rupture, two ruptured at the time of the initial attack and were at rest thereafter, and two had been on partial activity and will be considered to have been excessively active.

It is interesting to note that almost all authors dealing with large numbers of autopsy statistics have been struck by the fact that rupture is much more likely to occur during the first myocardial infarction. This is attested to by the absence of old scars and myocardial fibrosis in hearts with septal rupture when compared with deaths resulting from myocardial infarction without rupture.

Anatomical and electrocardiographic correlation was good in our series, with seven tracings showing the typical involvement in V1 and V2. The eighth showed diaphragmatic infarction, as did 13 per cent of the reported cases. Myers has shown that septal extension may be demonstrated pathologically in a high percentage of cases in the absence of electrocardiographic evidence.²⁰

Studies concerning the relationship of anticoagulants to cardiac rupture—not specifically septal—suggest that a causal relationship cannot be demonstrated. There are not enough cases reported in the literature with sufficient information to permit any conclusions in this regard. Of our own cases, five were given anticoagulants, and three were considered to be in therapeutic range.

In general, it does seem that septal rupture is more likely to occur in a patient who at the age of 60 or over has suffered her first transmural infarction, and in whom hypertension persisted after the infarction. Septal rupture can and does occur, however, in all age groups subject to myocardial infarction, in either sex, at rest or with activity, in the presence or absence of hypertension, and whether or not anticoagulants have been employed.

Treatment of the immediate post-rupture state is entirely symptomatic. Analysis of long survival cases in the literature gives no indication that any regimen is to be preferred, other than routine care of shock

*References: 1, 3, 5, 6, 7, 8, 9, 11, 12, 13, 16, 18, 21, 24, 25, 26, 28, 29, 31, 33, 34.

**References: 1, 2, 3, 7, 8, 11, 16, 18, 24, 26, 28, 29, 31, 33, 34.

***References: 1, 3, 5, 6, 7, 8, 9, 11, 13, 16, 18, 19, 21, 23, 24, 25, 26, 27, 28, 29, 31, 33, 34.

Figure 1

AGE	SEX	PEVIOUS HYPER- TENSION	B/P IN HOSPITAL	VESSEL INVOLVED	SIZE OF PERFORA- TION	ACTIVITY	PREVIOUS INFARCTION	INFARCT TO RUPTURE	RUPTURE TO DEATH
70	F	Yes	188/90	L. Ant. Desc.	1 cm. dia.	None	No	4-6 hours	31 hours
61	M	No	80/64	L. Circumflex	3 x 1.5 cm.	None	No	1.5 hours	46 hours
65	F	Yes	170/110	L. Ant. Desc.	1 cm.	None	No	3.5 days	1.5 hours
56	F	Yes	140/100	L. Ant. Desc.	2 cm. slit	None	No	6 days	7 days
62	F	Yes	240/120	Not stated	.7 cm.	Yes	No	8 days	1 day
71	F	Yes	80/40	Ant. Desc.	1 x 1 cm.	Yes	No	4 days	2 days
65	F	Yes	140/90	Ant. Desc.		None	No	7 days	1 day
57	M	Yes	110/70			None	No	3 days	10 hours

AGE	SEX	EKG	ANTI- COAGU- LANTS	PRO- THROM- BIN TIME	CYANO- SIS	SHOCK	RIGHT FAILURE	LEFT FAILURE	LOCATION OF MURMUR	THRILL
70	F	Acute anterior	Yes	18 secs.	No	Yes	No	No	Medial to apex	No
61	M	Postero-lateral	No	18.2 secs.	No	Yes	No	Yes	3-4 LICS	Yes
65	F	Antero-septal	Yes	60.1 secs.	Yes	Yes	No	No	Diffuse	No
56	F	Antero-septal	Yes	25 secs.	No	Yes	No	Yes	3-4 LICS	Yes
62	F	Antero-septal	No		No	Yes	No	Yes	4-5 LICS	No
71	F	Anterior	No	26 secs.	No	Yes	No	No	4 LICS	No
65	F	Anterior	Yes	28 secs.	No	Yes	No	Yes	4 LICS	Yes
57	M	Inferior	Yes		Yes	Yes	No	Yes	3-4 LICS	Yes

and heart failure. All cases surviving several weeks post-rupture have shown right-sided heart failure,^{28, 8, 33} so that early digitalization and use of mercurial diuretics is indicated. If life can be maintained for 10 to 12 weeks, operative closure under direct vision is definitely indicated. A case of this nature has been successfully done by Dr. Cooley of Baylor University.⁹

Prognosis

Prognosis of IV septal rupture following myocardial infarction is uniformly poor. Reports of survival for a period of years are rare.²⁷ Most patients die within a few days, and the greater percentage are dead within three months. It is for this reason that early repair of the defect in patients surviving the original rupture is indicated.

Summary

(1) The significant clinical facts concerning eight cases of IV septal rupture due to myocardial infarction are presented. In each case, the diagnosis was made during life and proven at autopsy.

(2) An attempt has been made to sum up the predictability, differential diagnosis, treatment, and prognosis of IV septal rupture due to myocardial infarction.

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Georgia Healthier in 1956

HOW HEALTHY WERE YOU in 1956?

Some of your tax dollars came back home to you last year in the unseen form of greater freedom from disease. Your health was protected in many ways which you could see and in others of which you were not aware.

The Annual Report of the Georgia Department of Public Health was presented April 18 by Thomas F. Sellers, director, to the Governor, the State Board of Health, and the people of Georgia.

For the sum of slightly over \$7 million or about \$2 per person (plus the health share in local taxes) the people of Georgia purchased a higher level of health than ever before.

On the credit side, Dr. Sellers pointed out the establishment of 14 new health districts, bringing the total to 18. The state's 159 counties are forming 38 districts to stretch tax dollars for more effective use of personnel and equipment.

Live births are increasing with 1956 the third year recording over 100,000.

Georgia improved somewhat as a place for safe childbirth, although hospital care for rural mothers is often still lacking; the 1955 Midwife Act helped eliminate several dangerous midwives.

The environment we live in is becoming increasingly safer, as sanitation standards increase in food, milk, housing, tourist courts, schools, hospitals, insect and rodent control, and water and sewage control. Of special interest is the reduction of home accident deaths by 11 per cent over 1955.

We saw 50,000 more people drinking fluoridated water which reduces tooth decay two-thirds in children, giving them lifelong benefits. The total is now 600,000.

Another bright spot, Dr. Sellers said, is the fact that although rabies has not been eradicated, it is under control for the first time in the history of the Health Department. There is still a wild animal problem, chiefly among foxes.

The other side of the health picture, Dr. Sellers said, shows that every milepost brings new ones into view. With communicable diseases at an all time low, killing fewer people, more people are living long enough to encounter a new set of diseases—the degenerative diseases.

New industries, desirable as they may be, introduce a host of occupational health hazards which require constant study and checking. Investigations were made last year in 231 establishments.

SARCOMAS OF THE PELVIS—HEMIPELVECTOMY

F. JAMES FUNK, JR., M.D., and STERLING JERNIGAN, M.D., Atlanta, Georgia

A review of experience with palliative surgery in four cases over a two-and-one-half year span

THE AMPUTATION NOW KNOWN as hemipelvectomy, or hind-quarter resection, was first performed by Billroth in 1889. Drs. King and Steelquist, in reviewing the 54 years that followed this event, found 110 reported with a recorded operative mortality of nearly 60 per cent. In 1946, Drs. Beck and Bickel of the Mayo clinic found that the surgical mortality in the reported cases between the years of 1934 and 1946 had dropped to approximately 20 per cent. Since that time, in the smaller series reported, the surgical mortality has fallen even lower.

It is not the purpose of this paper to present a new technique or surgical approach to the problem of pelvic sarcoma, but rather to review our experience with four cases over a two and a half year span. Sarcomas of the pelvis are usually painful. All of ours were extremely so. They are rarely amenable to x-ray therapy or chemotherapy and as a result invariably present a distressing problem for the surgeon as well as the patient. Four cases make up the body of this report: a fibro-sarcoma arising from the obturator membrane, a medullary fibro-sarcoma involving both the femur and the ischium, a chondro-sarcoma of the greater trochanter, and a chondro-sarcoma of the ilium.

Case I

In February of 1954, Mrs. P. B., a 36-year-old lady, was seen with a large painful mass in the left adductor region. This was first found the previous September, one month after she had delivered a normal child. She had had hip pain in this area for the last five months of her pregnancy following

an earlier fall. Examination showed a lady who was in severe pain which was increased by any hip motion on the affected side. A large, irregular, firm mass was found in the left adductor area in the proximal thigh, and x-rays revealed a soft tissue mass with calcification which appeared to extend into the true pelvis and displace the abdominal contents. (Figure 1.) A biopsy was done which revealed fibrosarcoma, and 16 days later a hemipelvectomy was performed. The tumor appeared to extend both distally and proximally from the obturator foramen. The intrapelvic portion of the tumor displaced the viscera, but no direct invasion was found. She had an excellent post-operative course and was put in a wheel chair on the ninth post-operative day and ambulated on the eleventh post-operative day. Since her discharge from the hospital she has been seen at frequent intervals, and there has been no evidence of recurrence by x-ray (Figure 2) or clinical examination.

Figure 1



Figure 2



Case II

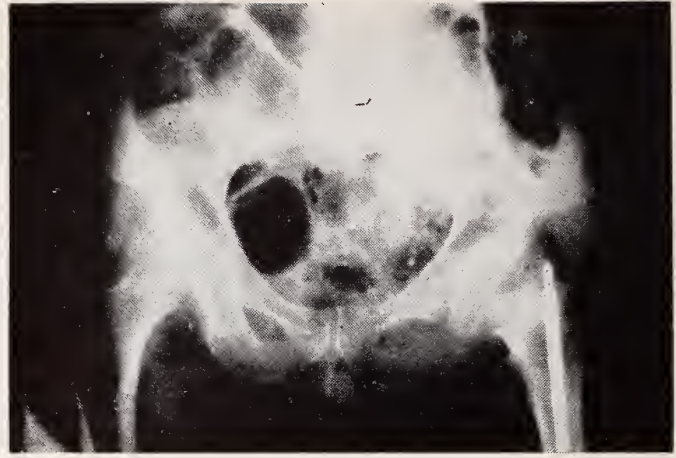
In April of 1955, Mr. C. H., a 70-year-old man, was seen with a story of left hip and thigh pain of three months' duration, with tenderness over the upper thigh and in the region of the ischium. X-rays revealed lytic lesions in the upper femoral shaft

Figure 3



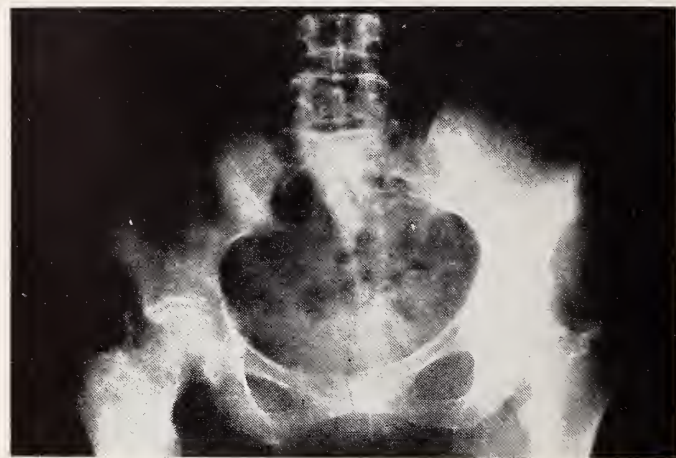
(Figure 3) and in the ischium of the same side. He was admitted to the hospital, and a needle biopsy of the femur was performed which showed the pathological picture of fibro-sarcoma. X-ray therapy was given, and he was sent home only to suffer a pathological fracture one week later when he turned in bed. Following his re admission to the hospital, the femoral fracture was nailed with an intramedullary nail. Fixation was poor. He continued to have pain in the region of the femoral fracture as well as in the ischium, and the degree of destruction in this latter area made a collapse of the acetabulum appear imminent. (Figure 4) No evidence of malignancy was found proximal to the pelvis, and after considerable discussion a hemipelvectomy was performed. When the ilium was removed, it was found that the malignancy had crossed the sacroiliac joint and had invaded the wing of the sacrum. This, too, was resected, but the tumor extended well into the body of the sacrum and removal was impossible.

Figure 4



Postoperatively he did well except for a temporary urinary fistula arising from the urethra which cleared on catheter drainage. His palliation was excellent. By the third day he said that he was more comfortable than he had been during the pre-operative weeks. During the succeeding months he was seen occasionally as an outpatient and in general was

Figure 5



largely free of pain and cheerful. He died at home in October of 1955.

Case III

Mrs. E. S. was a 51-year-old lady who was seen October 1, 1955, with a story of hip and thigh pain on the right side, of five years' duration. This pain had been annoying her for years, but during the months prior to admission it had become increasingly severe and disabling. Examination showed a diffuse enlargement of the upper thigh with a firm, painful mass extending over the greater trochanter (Figure 5). Movement of the affected hip caused severe pain. A biopsy was performed which was interpreted as osteogenic sarcoma. A hemipelvectomy was done, and the final pathological picture demonstrated an anaplastic bone-forming tumor arising from a chondro-sarcoma. Microscopically the lesion could be interpreted either as chondro-sarcoma or osteogenic sarcoma, depending on the site of the tissue. Post-

operatively the wound healed well, but she developed left pleural fluid which was thought at first to represent a pulmonary infarction. Her subsequent course proved this to be metastatic involvement. She was discharged and followed in the out-patient clinic; she died a respiratory death in late January of 1956.

Case IV

D. J. was a poorly nourished 16-year-old colored girl, who was first seen in February of 1956 with a large mass in the region of her left iliac crest and a history which dated back to the previous September when the mass was first discovered. The hip was held in a rigid flexion-abduction position which was so painful that turning in bed was a difficult problem. X-rays revealed an osteo-cartilaginous neoplasm of the ilium which extended so far proximally as to make surgical extirpation questionable (Figure 6). X-rays of the chest were negative. After biopsy, a hemipelvectomy was performed without difficulty. The pathological diagnosis was chondro-sarcoma. Although at surgery the tumor seemed to be entirely

Figure 6



removed, specimens taken from the sacroiliac joint proved on later microscopic examination to contain neoplasm. The wound healed per primam, and walking was begun on crutches at an early date; she was discharged from the hospital to be followed in the out-patient clinic. Recent films have shown recurrence in the region of the sacroiliac joint, and metastases are now visible on chest X-ray.

The surgical plan employed in these cases has been well described by Drs. King and Steelquist. We feel that the procedure itself may be facilitated

by the presence of two surgeons who at times during the operation are able to work simultaneously thus shortening the surgical time. One point in technique cannot be stressed too strongly, namely: the need for preserving the inferior gluteal vessels with their all-important blood supply to the gluteus maximus and overlying skin which forms the posterior flap. These must be carefully dissected from the outer structures that leave the greater sciatic notch. We have found it advisable to perform the procedure in the side-lying position with the entire extremity draped free in such a way that it can be manipulated and at times supported by a sterile Mayo stand.

Although positive conclusions are impossible in so short a series, several lessons have been learned. First, the problem of palliation in these miserable individuals is one which frequently can only be solved by removing these large neoplasms. Secondly, we feel the possibility of cure is a real one when the lesion is detected before it has approached the limits of the pelvis proximally. It is well to note that in this and other series the "cure rate" is far higher than in such commonly operated malignancies as bronchogenic and gastric carcinomas. Finally, the amputation itself is not nearly so disabling and mutilating as is commonly supposed. The sphincters are left intact, bodily functions are carried out in a normal way, and the loss itself occasions no pain.

Summary

In summary, four cases of sarcoma in the pelvic region have been presented. All of these were treated by hemipelvectomy. There was no operative mortality. Of the four, two are now dead of their disease, one is living with the disease, and one has gone more than two years without evidence of neoplasm. Appraising the three cases in which cure has not been obtained, we have felt that the palliation obtained justified the surgery.

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Do You Know?

TWENTY-SEVEN PER CENT of all drivers involved in fatal auto accidents in the U. S. last year were under 25 years of age. Approximately 4½ per cent of the total number of fatal accidents on the highways are caused by driver fatigue and going to sleep

at the wheel. More than 78 per cent of vehicles involved in fatal accidents in 1955 were traveling straight ahead; 85 per cent were passenger cars. Three out of four traffic accidents happen in clear weather on dry roads.

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PREVENTION OF NOREPINEPHRINE (Levophed) SLOUGHS

***Regitine injected into Levophed extravasations
has been found to be dramatically effective
in preventing necrosis of soft tissue***

SINCE NOREPINEPHRINE (Levophed) first became commercially available in 1949 this potent adrenergic agent has been used to prevent and treat hypotension caused by myocardial infarction, gram negative bacteremia, vascular catastrophe in the central nervous system, spinal anesthesia, sympathectomy, excision of pheochromocytomas, and adrenalectomy. This agent (Levophed) appears to be most beneficial in correcting hypotension which is not associated with a blood volume deficiency.¹ Various authors have failed to agree on the value of the drug in the treatment of traumatic and hemorrhagic shock.^{2,3,4,5}

A distressing and not infrequent complication associated with the administration of a continuous drip of norepinephrine has been the production of extensive soft tissue sloughs. During a 12-month period at Grady Memorial Hospital, six patients have had tissue sloughs associated with the administration of intravenous solutions containing norepinephrine. The following patient is reported to illustrate that extreme caution must be maintained when this drug is given intravenously for a prolonged period.

Case Report

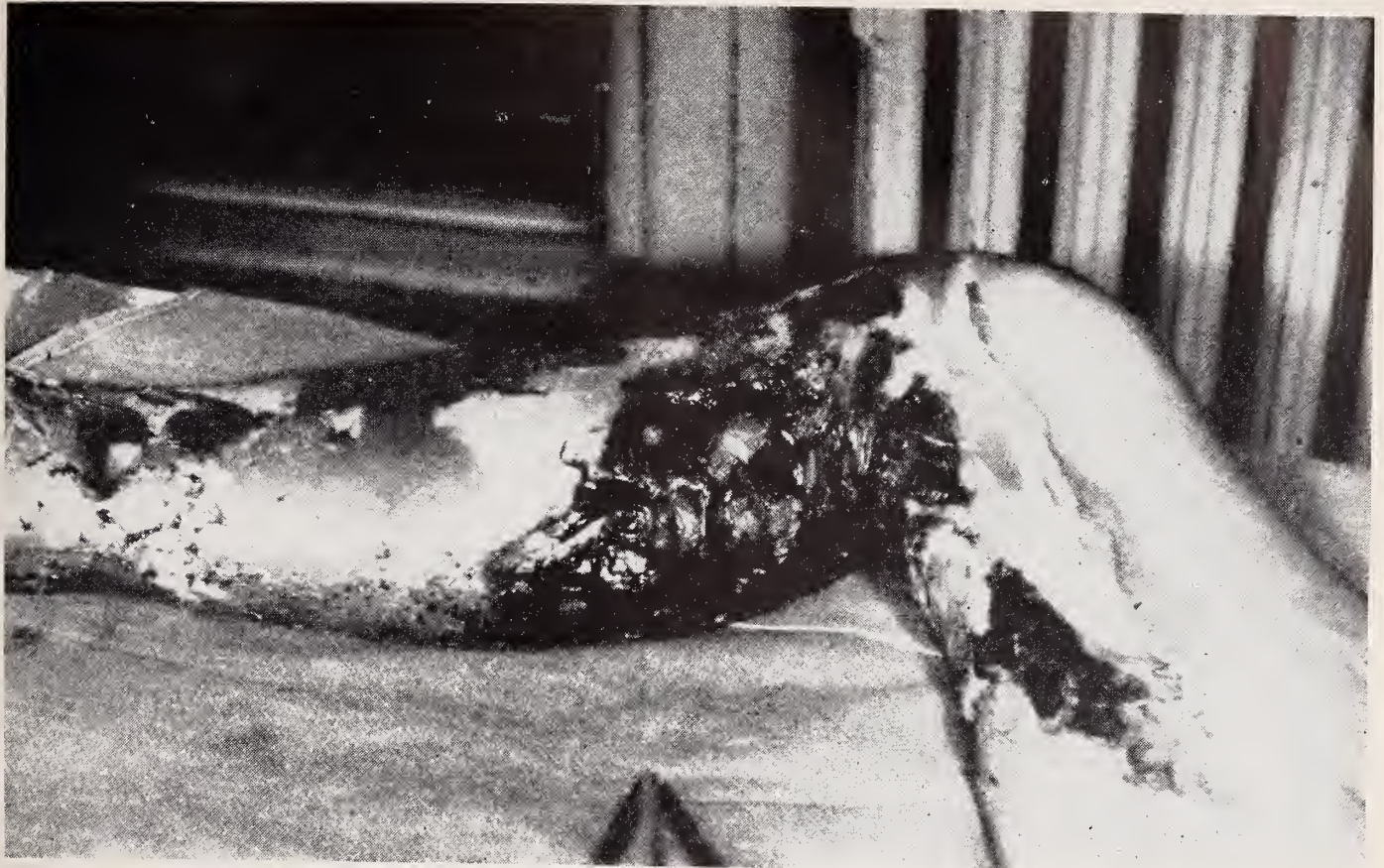
W. R., No. 090-500-1. This 55-year-old male was admitted to Grady Memorial Hospital on August 26, 1955, complaining of difficulty in urination. For the past year he had noted difficulty starting his urinary flow and a decrease in the size and force of the urinary stream. Physical examination revealed a well developed, well nourished male, with a blood pressure of 140/85. Slight tenderness was noted in the suprapubic region. The dome of the urinary bladder was palpable two inches above the pubic symphysis.

Rectal examination revealed benign prostatic hypertrophy.

After appropriate study, a transurethral resection of the prostate was performed. He did well until the following day, at which time he developed postoperative hemorrhage which required multiple blood transfusions and re-operation to control the bleeding. Hypotension persisted in spite of hemostasis and continued blood replacement. A cut-down was performed in the left ankle so that his hypotension could be corrected with an intravenous drip of five per cent glucose in water containing eight micrograms (two ampules) of Levophed per 1,000 cc. Blood cultures revealed a gram negative bacteremia, the organism being sensitive to Terramycin. In order to maintain his blood pressure at 90 mm. Hg. systolic, it was necessary to continue the intravenous drip of norepinephrine three days. On the third day, massive extravasation of norepinephrine occurred into the soft tissue of the leg. Subsequently, the patient developed extensive soft tissue sloughs on his left foot, leg, and lower thigh (Figure 1). Multiple skin grafting procedures were performed, and his hospital stay covered several months. Finally, due to extensive destruction of the muscles and tendons and the development of osteomyelitis of his tibia, a supracondylar amputation was performed on May 24, 1956. He was finally discharged from the hospital and is now up and about on crutches awaiting an artificial leg.

In an effort to clarify the pathogenesis of norepinephrine sloughs and to determine how these sloughs could be prevented,⁶ the following studies have been performed on dogs.

Figure 1



Patient No. 090-500-1. Appearance of left leg three weeks following extravascular infiltration of L-norepinephrine.

Experimental Observations

A. *Studies on Etiology of Tissue Sloughs*

1. Solutions containing Levophed have been infused into the small veins of the legs and into large veins such as the femoral vein and vena cava. In several animals the infusions have been given for short periods of time; in others, continuously for periods up to 72 hours. As long as extravascular infiltration did *not* occur, soft tissue sloughing was prevented.

2. Studies were performed on the effects of a slow subcutaneous drip infusion and a rapid subcutaneous injection of solutions containing Levophed. Quite unexpectedly, it was found that the test solution containing Levophed could be rapidly injected into the subcutaneous tissues without producing necrosis of the tissues. However, if the same quantity of test solution were given by a slow drip infusion into the subcutaneous tissues, soft tissue necrosis routinely occurred.

B. *Studies on Prevention of Tissue Sloughs*

After the procedure for routine production of soft tissue necrosis was standardized, methods to prevent necrosis of tissues by Levophed were studied.

1. Saline, procaine, papaverine, histamine, hyaluronidase, and hydrocortisone were injected into

the Levophed extravasation and found to be ineffectual in preventing soft tissue sloughs.

Figure 2



Right thigh shows the slough produced by slowly infusing a test solution containing L-norepinephrine into the subcutaneous tissues. The same quantity of test solution was infused into the left thigh; however, one hour later, 10 mg. of Regitine was injected into the extravasation and necrosis of the soft tissues was prevented.

Figure 3



Typical appearance of a "Levophed slough" produced by extravascular infiltration of L-norepinephrine. Note that extravasation occurred even though the solution containing L-norepinephrine was being infused through a polythene catheter inserted via a cutdown.

2. Regitine (10 mg. in 20 cc. saline) injected into the Levophed extravasation was found to be dramatically effective in preventing necrosis of soft tissue (Figure 2). Levophed sloughs could be prevented if Regitine were injected into the extravasation within 12 hours following the completion of the subcutaneous drip infusion. Preliminary observations indicated that the injection of Regitine into a "Levophed extravasation" did not produce secondary hypotension.

Discussion

Norepinephrine (Levophed) is a potent necrotizing agent if allowed to extravasate into the subcutaneous tissues (Figure 3). When it is given intravenously, precautions should be taken to prevent extravascular infiltration. Dramatic local changes occur when norepinephrine infiltrates subcutaneously. The overlying skin becomes mottled and pale, and on palpating the skin, one is impressed by the marked drop in local skin temperature. These local signs of ischemia can be reversed, and necrosis of soft tissue can be safely prevented by diluting 10 mg. of Regitine in 20 cc. of saline and injecting this mixture into the area of extravasation. Regitine is an adrenergic blocking agent which does not appear to interfere with the maintenance of blood pressure (Figure 4) when injected into an area of norepinephrine extravasation.

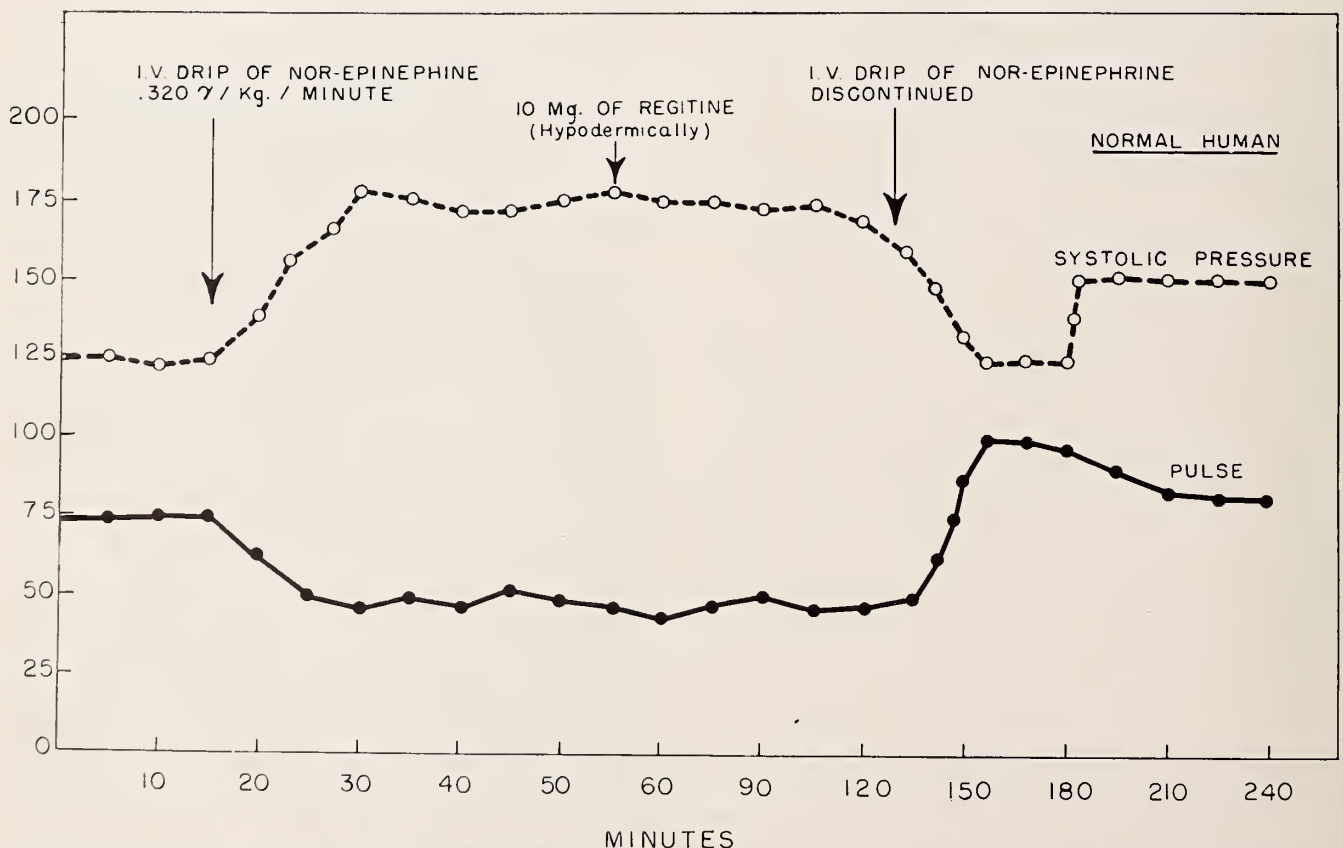
Since these studies were completed, we have become aware of the work of McGinn and Schluger.⁷ Our findings are similar to theirs and add support to their observations.

Summary

1. Patients who are being treated with norepinephrine must have constant attention by an attendant who understands the dangers associated with the intravenous administration of this drug.

Figure 4

EFFECT OF NOR-EPINEPHRINE AND REGITINE ON PULSE AND SYSTOLIC PRESSURE



This figure graphically shows that 10 mg. of Regitine injected subcutaneously into a normal human, who was made hypertensive with Levophed, does not affect the blood pressure or the pulse rate.

The Month in Washington

Washington, D. C.—The 85th Congress is in the final few weeks of its first session with prospects that it will enact few major medical bills this year, but that next year will be a different story. On at least half a dozen important measures action has been postponed with the understanding that the issues will be fought out in 1958.

Circumstances prevented any delay on one bill that is of considerable importance to the younger doctors—a new version of the doctor draft act. It had to be enacted by July 1, the Defense Department insisted, or not enough doctors would be available to maintain the military medical services at an acceptable level.

The problem is that the Armed Forces require a higher ratio of physicians to troops than exists between physicians and the general population. Without some special law, the services would either have to make out with fewer doctors than they say they need, or draft thousands of non-physicians merely to obtain the doctors who are in the particular age groups.

This scheme was devised: Amendment of the regular draft act to allow the call up, to age 35, of the necessary numbers of doctors from among those who had received educational deferments; they could be called because they are physicians, not because they are of a certain age. Also, the national, state, and local Medical Advisory Committees of Selective Service would be continued, as would a number of provisions in the original act that protect the rights of drafted doctors.

As Congress moved toward adjournment, prospects also were that it would enact a bill to help out some states caught in a financial squeeze because of a new act, passed last year but not scheduled to go into effect until July 1, 1957, to increase federal pay-

ments for the medical care of persons on the state-federal public assistance rolls.

Under the old system, states could use the U. S. dollars to pay directly to the individuals for their medical care, or directly to the vendors of medical service—hospitals, physicians, dentists. Many states, adopting the second plan in all or part of their counties, used the federal money to help maintain pooled funds, which support various medical care programs.

All U. S. money paid out under the new act must be used in the form of vendor payments—that is, not turned over directly to the public assistance cases. At the same time, the law as originally passed stipulated that any money received under the old plan henceforth would have to be handled as “recipient payments,” that is going directly to the persons on public assistance rolls.

A number of states thus faced the prospects of drastically revising their carefully-established medical care programs or sacrificing large amounts of federal money. Congress came to their rescue by means of a bill that would allow them to use the old money as before, yet take full advantage of the new federal program.

In the closing weeks of the session, however, two major medical bills were making little, if any progress—those for federal grants to medical colleges to build teaching facilities and for initiating a program of health insurance for federal civilian employees.

A number of bills had been introduced on aid to medical education, representing virtually all the viewpoints in Congress and the administration, but nothing much was happening. Here one factor was the economy drive, which was not too successful in cutting the administration's health budget, yet which virtually precluded any new programs involving large appropriations.

... NOREPINEPHRINE SLOUGHS CONTINUED

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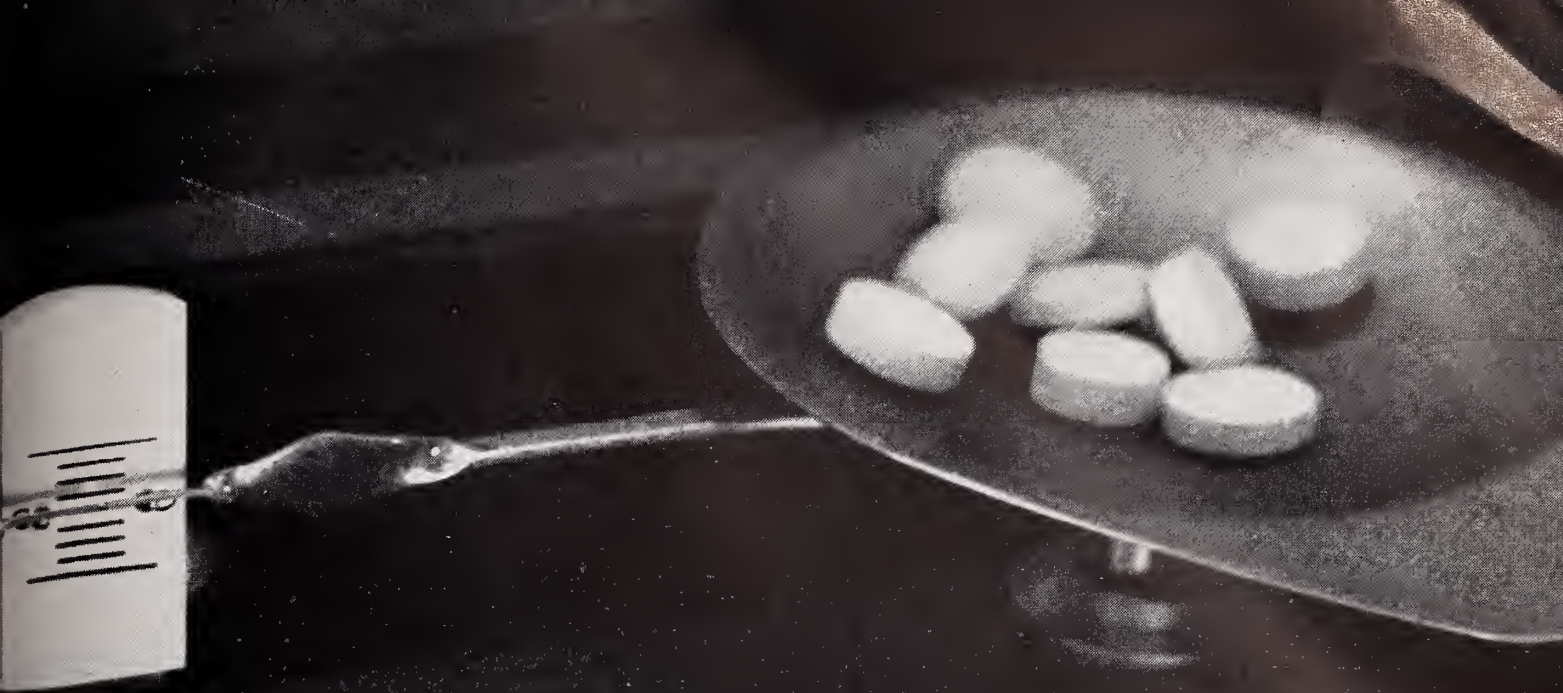
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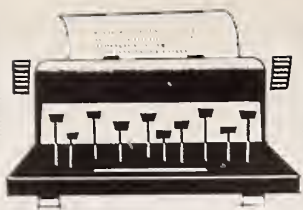
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editorials

DICKENS, OBESITY, AND DECOMPENSATION

CLASSIC DESCRIPTIONS of disease are by no means confined to the exclusive realm of the physician. A growing volume of clinical observations has recently been correlated with data from the cardiopulmonary laboratory to establish a newly recognized syndrome . . . the so-called Pickwickian Syndrome, or obesity heart disease. In his *Pickwick Papers*, published in 1837, Charles Dickens gave a classic description of the sign and symptoms of this syndrome. When he wrote of Mr. Wardle's boy, Joe, he described in detail this "fat and red faced boy in a state of somnolency." A characteristic of people with this syndrome is an extraordinary degree of somnolence in which sleep may overcome the patient when he is sitting up or even while he is engaged in conversation or other muscular activity. Excessive weight is secondary to excessive food intake.

Experimental observations have indicated that increasing abdominal girth, whether from an enlarged uterus, ascites, or obesity, is accompanied by a decreasing expiratory reserve and that, when the increase in girth is extreme, it may lead to a state of relative ventilatory insufficiency. Ventilatory studies on these patients have shown decreased total lung volume, decreased functional residual capacity, and decreased expiratory reserve volume. These in turn result in alveolar hypoventilation, arterial hypoxia, and hypercapnea.

In the presence of sustained hypoxia, one finds such symptoms as somnolence, twitching, and periodic respiration with cyanosis. With prolonged arterial hypoxia, secondary polycythemia and cor pulmonale result. Subsequently a right ventricular hypertrophy and right-sided failure emerge in this course of events. While digitalis and diuretics may provide some temporary respite from the resulting heart failure, only by prompt weight reduction can

the patient be salvaged from ultimate intractable failure and death. Actually obesity heart disease is somewhat of a misnomer since the heart dysfunction is secondary to pulmonary disease of an unusual variety. Fortunately many aspects of this syndrome are reversed by a significant loss of body weight. It is probable that most cases in which the association of polycythemia and obesity is present are examples of the Pickwickian Syndrome. Polycythemia has been found to be 10 times as prevalent in the pathologically obese as in an unselected hospital population. This syndrome is frequently confused with polycythemia vera. Unlike polycythemia vera there is no consistent increase in immature cells, white blood cells, or platelets accompanying the increase in red blood cells in the peripheral blood. The bone marrow examination may reveal mild erythroid hyperplasia, but diffuse hyperplasia involving the myeloid and megakaryocytic series characteristic of polycythemia vera is not observed.

The resulting cyanosis and arterial anoxemia may suggest a diagnosis of congenital heart disease with right-to-left shunt. This may be excluded by the observation that full arterial oxygen saturation is promptly achieved while the patient is breathing 100 per cent oxygen.

The periodic respiration seen in this syndrome differs from the usual Cheyne-Stokes breathing, in that periods of apnea alternate with periods of tachypnea rather than hyperpnea.

As these individuals lose weight, their somnolence, twitching, periodic respiration, dyspnea, and edema gradually subside; and in most patients the physical condition returns to normal. In one reported patient, with weight reduction the vital capacity increased from 0.46 to 1.8 liters. The physiologic dead space decreased from 372 ml. to 147 ml. Arterial blood saturation increased from 80 per cent to 98 per cent with weight reduction.

Despite the maintenance of a constant minute volume by an increased respiratory rate, alveolar ventilation falls as tidal volume falls, that is, as breathing becomes more shallow. Shallow breathing leads to alveolar hypoventilation because ventilation of the anatomic dead space must occur before alveolar ventilation can take place. Alveolar ventilation per breath equals tidal volume minus dead space ventilation per breath. Therefore, at a constant minute volume, any reduction of tidal volume will mean an automatic reduction of alveolar ventilation. When the reduction of tidal volume reaches a critical point, the maintenance of alveolar ventilation by means of increased respiratory rate becomes impossible even though it has been demonstrated that with tidal volumes, which are smaller than dead space volume, some alveolar ventilation takes place.

There is accumulating evidence that in all individuals there is a critical degree of obesity at which ventilatory insufficiency appears. This is extremely variable from person to person.

It is well known that prolonged exposure of the respiratory center to high levels of CO_2 in the blood produces adaptation so that there is an increase in arteriolar PCO_2 to a normal level. Since obesity leads to a low expiratory reserve volume and to a diminished functional residual capacity, these changes have certain practical disadvantages in that they deprive the patient of certain buffer mechanisms normally available, and permit unusual fluctuations in the blood gases.

The precise mechanisms of shallow respiration in the obese subject are not known. It is a fact that as the lung approaches the expiratory position the work of breathing increases. The obese man with a diminished expiratory reserve volume will do more work than is normally required to maintain his alveolar ventilation. Such an increase in work may conceivably lead to a change in the type of breathing. It has also been postulated that the mechanical barrier to respiration created by fat is of real significance. The increased total metabolic requirement secondary to increased body weight is also contributory.

Whatever the precise mechanisms, this recently explained but long observed syndrome lends eloquent credence to the old adage that man may literally eat himself to death.

JUNIOR-SENIOR DAYS

"... TO PROMOTE THE SCIENCE and art of medicine and the betterment of public health"—*MAG Constitution & By-Laws*, Article III.

In the interest of medical education and to anticipate medical needs of the people in Georgia, the Rural Health Committee of the Medical Association of Georgia and the Academy of General Practice jointly sponsored a Junior-Senior Day Program in May at each of the two medical schools in the state.

What is a Junior-Senior Day Program and how does it accomplish what?

These programs, designed for juniors and seniors, are a graphic presentation of the advantages of general practice for the doctor, patient and community.

Topics fully discussed at the Medical College of Georgia program were: "Why I Chose a Small Town to Practice Medicine," Maurice F. Arnold, Hawkinsville; "The Mechanics and Procedures in Establishing an Office," George H. Alexander, Forsyth; "Being a Doctor's Wife," Mrs. Walker L. Curtis, College Park; and "The Role of the Pharmaceutical Representative," Mr. William C. Mankin, Atlanta.

Students at Emory University School of Medicine heard Howard C. Derrick, Lafayette, discuss "What Is a General Practitioner?"; M. Freeman Simmons, Decatur, discussed "Practical Considerations in Setting Up a Practice;" and Mrs. Shelley C. Davis, Atlanta, presented a talk on "The Mrs.-MD Team."

Both programs were well attended, and Mead-Johnson & Company representatives were most gracious hosts at the social hour following the program.

This then is Association-Academy sponsored activity devoted to more medical services in our rural areas and the betterment of public health, through the *art* of medicine.

PLUMBING AND SURGERY

IT HAS OFTEN BEEN SAID that a plumber can be taught to operate, but he could not be expected to exercise surgical judgment. Unquestionably knowledge, judgment, and integrity are the three most important qualities desired in a surgeon, but what of surgical skill or technique? Surgical skill implies the ability to actively apply knowledge and judgment in executing an operation. How can this be translated in terms of dividends to the patient? It determines the gentleness used in handling tissues, the accuracy with which the tissues are dissected, the precision with which the tissues are reapproximated, and, lastly, the efficiency of the operation.

The individual surgeon is originally endowed with a certain amount of coordination which is great in some and small in others. Those fortunate enough to be in the former category require less practice to attain a high level of surgical skill as compared to the latter who require much more practice to gain the same degree of skill. Somewhat analogous to this is the "natural born ball player" and the ill-coordinated, determined boy who practices extra hard to become a good ball player.

So often practice to the surgeon consists only of learning to tie knots, which the beginning surgeon assiduously practices. But how often is the practice extended to tying knots in the bottom of a container, or in the corner of a deep box? Tying a knot in relatively inaccessible areas tests the real skill of knot tying. The practice should be extended to suturing and grasping small pieces of thread in improvised situations at home, analogous to the so-called "compromised situation" during surgery, which after practice and with perfection would no longer be a "compromised situation." The common instruments used in surgery should be handled and manipulated until their use becomes habit, so that they can be properly handled and used with ease, gentleness, and efficiency. This can never be fully developed at the

operating table without jeopardizing, to some extent, the patient on whom one operates.

The piano player who could use only the right or left hand well could be expected to execute only part of the interpretation of the music. The total interpretation requires the coordinated cooperation of both hands. Yet how often have we surgeons, in "compromised situations," wished we could use our other hand to suture, dissect, or grasp bleeders. With practiced ambidexterity the situation would no longer be compromised.

"The little things make perfection, but perfection is no little thing."

John R. Derrick, M.D.

A.M.A. HOUSE OF DELEGATES

ABLY REPRESENTING THE Medical Association of Georgia at the 106th Annual Meeting of the American Medical Association, New York City, June 3-7, 1957, were the Association's three official AMA Delegates: Charles H. Richardson, Sr., Macon; Eustace A. Allen, Atlanta; and Spencer A. Kirkland, Atlanta. Also taking an active part in hearing the proceedings of the three sessions of the AMA House of Delegates, conferring with our delegates and attending AMA reference committee meetings were Secretary-Treasurer Chris J. McLoughlin, Atlanta; Chairman of Council George R. Dillinger, Thomasville; Alternate Delegate and Councilor Henry H. Tift, Macon; and Mr. M. D. Krueger, Executive Secretary. Some 100 other Georgia physicians attended this session.

Three resolutions were introduced at the AMA House of Delegates in behalf of the MAG by our delegates. These resolutions and the AMA action on them is abstracted as follows:

Ancillary Specialties' Inclusion in 'Medicare'—suggested that AMA attempt to have existing Medicare regulations amended to incorporate the AMA policy that the practice of anesthesiology, pathology, radiology, and physical medicine constitute the practice of medicine, and that fees for services by physicians in these specialties should be paid to the physician rendering the service—*AMA House of Delegates approved.*

Blue Shield—Blue Cross Plans—suggested that the AMA House of Delegates set up a special committee to conduct a thorough study of the plans, contracts, policies, and other agreements of these organizations in reference to physician-patient relation-

ship, physician-hospital relationship, and discrimination, if any, in contracts to patients, to physicians, and to hospitals; and this study is to be conducted on a national level for report and recommendations to the 1958 AMA House of Delegates—*AMA House of Delegates approved with amendment that this study be conducted by an existing AMA committee concerned with this.*

VA Hospital Construction—suggested that AMA oppose the establishment of any further veterans' facilities for the care of non-service-connected illnesses of veterans—*AMA House of Delegates approved.*

Further action taken by the AMA House of Delegates is summarized in the succeeding paragraphs and certainly warrants MAG members' close attention.

New Principles of Medical Ethics—The House approved the long-discussed revision of the Principles of Medical Ethics, originally submitted at the 1956 annual meeting in Chicago. The final version, presented by the Council on Constitution and By-laws and then amended by reference committee and House discussions in New York, now reads as follows:

PREAMBLE

"These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

"*Section 1.* The principle objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

"*Section 2.* Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

"*Section 3.* A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

"*Section 4.* The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

"*Section 5.* A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

"Section 6. A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

"Section 7. In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

"Section 8. A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

"Section 9. A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

"Section 10. The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community."

In approving the new Principles of Medical Ethics, the House of Delegates also reaffirmed the "Guides for Conduct for Physicians in Relationships with Institutions," adopted in 1951, and asked the Board of Trustees to devise and initiate a campaign to educate both physicians and the general public to the dangers inherent in the illegal corporate practice of medicine in its various forms.

Guides for Relations with UMWA Fund— In a key action on the basic issue of third-party intervention, as it affects the patient's free choice of physician and the physician's method of remuneration, the House adopted the "Suggested Guides to Relationships Between State and County Medical Societies and the United Mine Workers of America Welfare and Retirement Fund," which were submitted by the A.M.A. Committee on Medical Care for Industrial Workers. In approving the guides, the House also recommended that the Board of Trustees study the feasibility and possibility of setting up similar guides for relations with other third-party groups such as management and labor union plans.

The statement, which outlines both medical society and UMWA responsibilities, contains these "General Guides":

"1. All persons, including the beneficiaries of a third-party medical program such as the UMWA Fund, should have available to them good medical

care and should be free to select their own physicians from among those willing and able to render such service.

"2. Free choice of physician and hospital by the patient should be preserved:

"a. Every physician duly licensed by the state to practice medicine and surgery should be assumed at the outset to be competent in the field in which he claims to be, unless considered otherwise by his peers.

"b. A physician should accept only such terms or conditions for dispensing his services as will insure his free and complete exercise of independent medical judgment and skill, insure the quality of medical care, and avoid the exploitation of his services for financial profit.

"c. The medical profession does not concede to a third party such as the UMWA Welfare and Retirement Fund in a medical care program the prerogative of passing judgment on the treatment rendered by physicians, including the necessity of hospitalization, length of stay, and the like.

"3. A fee-for-service method of payment for physicians should be maintained except under unusual circumstances. These unusual circumstances shall be determined to exist only after a conference of the liaison committee and representatives of the Fund.

"4. The qualifications of physicians to be on the hospital staff and membership on the hospital staffs is to be determined solely by local hospital staffs and by local governing boards of hospitals."

The Medicare Program—The House considered three resolutions dealing with the federal government's Medicare program for the dependents of servicemen. The delegates adopted one resolution condemning any payments under the Medicare program "to or on behalf of any resident, fellow, intern, or other house officer in similar status who is participating in a training program." Government sanction of such payments, the House declared, would give impetus to the improper corporate practice of medicine by hospitals or other nonmedical bodies. Such proposals, the House added, would violate traditional patterns of American medical practices, seriously aggravate problems of hospital-physician relationships, encourage charges by hospitals for residents' services to patients not under the Medicare program, and create a variety of additional problems in such areas as medical licensure and health insurance.

In another action on Medicare, the House recommended that the decision on type of contract and whether or not a fee schedule is included in future contract negotiations should be left to individual state determination. In this connection, however, the House restated the A.M.A. contention that the Dependent Medical Care Act as enacted by Congress does not require fixed fee schedules; the establishment of such schedules would be more expensive than permitting physicians to charge their

normal fees; and fixed fee schedules would ultimately disrupt the economics of medical practice.

New Statement on Medical Schools—To replace the “Essentials of an Acceptable Medical School,” initially approved by the House of Delegates in 1910 and most recently revised in 1951, the House adopted a new statement entitled “Functions and Structure of a Modern Medical School.” Presentation of the document followed a year of careful study by the Council on Medical Education and Hospitals in collaboration with the Association of American Medical Colleges.

The statement is intended to provide flexible guides which will “assist in attaining medical education of ever higher standards” and “serve as general but not specific criteria in the medical school accreditation program.” The document encourages soundly conceived experimentation in medical education, and it discourages excessive concern with standardization.

“No rigid curriculum can be prescribed for accomplishing the objectives of medical education,” it states. “On the contrary, it is the responsibility of the faculty of each school continually to re-evaluate its curriculum and to provide in accordance with its own particular setting and in recognition of advances in science a sound and well-integrated educational program.”

Occupational Health Programs—The House also approved a new statement on the “Scope, Objectives and Functions of Occupational Health Programs,” submitted through the Board of Trustees by the Council on Industrial Health. The Board report to the House said: “The statement describes and defines orthodox in-plant medical programs as understood in this country today and distinguishes clearly between such programs and the various plans for comprehensive medical care of the sick. It should help to resolve misunderstandings concerning the specialty of occupational medicine.”

In adopting the statement, the House agreed with a reference committee report which declared that “the House has before it a statement which for the first time clearly defines the scope, objectives, and functions of occupational health programs. It marks the needs and boundaries of occupational medicine. It states in a positive fashion the proper place of occupational health programs in the practice of medicine, and it clearly charts the pathways of communication between physicians in occupational

health programs and physicians in the private practice of medicine.”

Social Security for Doctors—Two resolutions favoring compulsory inclusion of physicians in the federal Social Security system and another one calling for a nationwide referendum of AMA members on the issue were rejected by the House. The delegates reaffirmed their opposition to compulsory coverage of physicians under the Old Age and Survivors Insurance provisions of the Social Security Act. They also recommended a strongly stepped-up informational program of education which will reach every member of the Association, explaining the reasons underlying the position of the House of Delegates on this issue. The House at the same time reaffirmed its support of the Jenkins-Keogh Bills.

Miscellaneous Actions—In considering 66 resolutions and many additional reports from the Board of Trustees, councils and committees, the House also:

Recommended further study and a progressive program of action, probably including legislative changes, to solve the problem of *narcotic addiction*;

Urged a more careful screening of television and radio patent medicine *advertisements*;

Directed the Board of Trustees to investigate the indiscriminate use of stimulants such as *amphetamine*, particularly in relation to athletic programs;

Directed the Speaker to appoint a committee of five House members to study the *Heller Report*, a management survey of the Association’s organizational mechanisms;

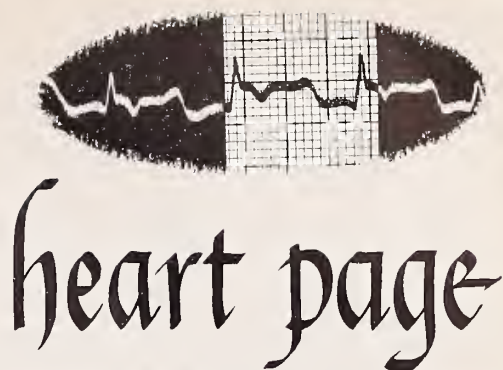
Commended the Law Department for its special report on *professional liability* and urged state and county medical societies to establish claims prevention programs and to show the new film, “The Doctor Defendant;” and

Condemned the compulsory assessment of medical men and staff members by hospitals in *fund-raising campaigns*.

Gunnar Gunderson, LaCrosse, Wisconsin, was unanimously chosen AMA President-Elect, and David B. Allman, Atlantic City, N.J., was installed as AMA President. Physician registration at this session reached an all-time high of over 19,000. The Illinois State Medical Society made a record state society contribution to the American Medical Education Foundation by turning over \$170,450 to the Foundation; many other state societies contributed somewhat lesser amounts. This report covers only a few of the many important subjects dealt with by the House of Delegates and is not intended to be a detailed report of all actions taken. MAG members are urged to read the complete proceedings of this session, which will be published in future issues of the *Journal of the American Medical Association*—

DIRECT VISION OPEN HEART SURGERY

DAN BURGE, M.D., Atlanta, Georgia



THE EXTRACARDIAC SHUNT procedures initiated by Blalock and Taussig have prolonged the lives of thousands of children with congenital heart disease. Intracardiac surgery performed by fingers and instruments guided entirely by the sense of touch has contributed greatly to the treatment of rheumatic valvular disease. Atrial septal defects have been successfully repaired by invagination of the atrial wall so as to occlude the defect. These anomalies have also been corrected through use of a funnel shaped "well" attached to the edges of an atrial incision. The operator's hands and instruments are introduced to the defect through the pool of blood which rises in the well.

Although these and other blind procedures are ingenious, they may prove to have served chiefly in pointing out the need for better methods. Adequate exposure of a bloodless field, under direct vision, for a time sufficient to properly correct the defect with heart action temporarily stopped, are the ideal conditions to be sought. Great progress has been made toward practical realization of these criteria.

In the laboratory, cardiac inflow occlusion was first used in 1907 for open heart surgery in dogs. Hypothermia, induced by rapid body cooling, lengthened the "safe period" of inflow occlusion sufficiently to permit use of the method in human subjects. In recent years hypothermia has been used successfully in several centers. Pulmonary stenosis, aortic stenosis, and interatrial septal defect are corrected, using this method, during circulatory occlusion lasting eight minutes or less. Workers using these techniques have stated that a mortality risk of less than five per cent should obtain in correction of these lesions. The primary limiting factor in hypothermia is the brief interval during which the circulation may be occluded safely. Many intracardiac defects require more time than may be taken during inflow occlusion, during hypothermia.

Another development has been the use of controlled cross-circulation from a donor by means

of a mechanical pump. This enables complete by-pass of the heart during surgery—at normal body temperature. Blood flows of one-sixth to one-fourth of normal resting cardiac output were sufficient for tissue needs during the by-pass period. Soon after the first use of the cross-circulation method, several types of pump-oxygenators came into use. These machines perform heart and lung functions during intracardiac surgery. Pump-oxygenators draw blood from the patient's cannulated vena cavae, expose the blood to oxygen, permitting gas exchange, and return the blood to a major artery. This technique permits longer and more complex intracardiac surgery.

One further refinement, used with either the oxygenator or with hypothermia, is that of elective cardiac arrest. If the heart continues to beat during the open heart phase, the myocardium maintains a significant demand for oxygen. Coronary flow is returned to the heart cavities via coronary sinus and Thebesian veins, thus obscuring the surgical field. Brief aortic occlusion has been used to circumvent this difficulty. However, such occlusion may cause serious myocardial ischemia in a beating heart. At rest the myocardium is far more tolerant of anoxia than at work. Controlled cardiac arrest is being tried as an answer to this problem. After cardiac bypass is established, potassium citrate solution, mixed with heparinized blood, is injected into the occluded aorta just above the coronary ostia. Asystole is promptly induced, providing a motionless dry field. Heart action is re-instituted by removing the aortic clamp, permitting inflowing blood to wash the potassium salt from the coronary system. Sinus rhythm is quickly re-established.

With these and yet-to-be devised methods, surgery of congenital and acquired heart disease will be greatly advanced in the next few years. It seems reasonable to expect that nearly all congenital cardiac anomalies which permit life beyond the first few months may become amenable to surgical correction. Direct vision procedures should eventually replace

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association

present methods of valve surgery in rheumatic heart disease.

Until recently this work has been confined to a small group of institutions where the pioneer re-

search was done. During the coming year or two many hospitals across the country may afford direct vision, open heart surgery. This number will include at least five Georgia hospitals.

Physicians Newly Licensed in Georgia

- John Morgan Albea
2478-A Skyland Rd., Chamblee, Ga.
- James Elmer Anthony, Jr.
Presbyterian Hosp., Chicago, Ill.
- Lionel Gennaro Barraza
811 Sussex Dr., Phenix City, Ala.
- George Edmund Beckmann, Jr.
744 McCallie Ave., Chattanooga, Tenn.
- Julius Frederick Boettner
13 S. W. 16th St., Fort Lauderdale, Fla.
- Franklyn Phillip Bousquet
390 Main St., Worcester 8, Mass.
- Jack Leon Cantor
312 Roanoke Ave., Riverhead, N. Y.
- Charles Calhoun Corley, Jr.
1530 Shoup Court, Decatur, Ga.
- John Thomas Daves
Florida State Hospital, Chattahoochee, Fla.
- Nicholas Edward Davies
55 Lake Forrest Lane, Atlanta 5, Ga.
- John Joseph Doolan, Jr.
Eugene Talmadge Memorial Hosp., Augusta, Ga.
- David Marsh Drylie
1518 Williams Lane No. 5, Decatur, Ga.
- Woodrow George Ellis
3836 Duck Ave., Key West, Fla.
- William Walker Evans,
450 Rock Springs Rd., N.E., Atlanta, Ga.
- Jerry John Everett
Memorial Hosp. of Chatham Co., Savannah, Ga.
- George Elmer Firth, II
1001 Haworth St., Philadelphia, Pa.
- Robert McCreery Flowers
1233 Forest Ave., Columbus, Ga.
- William Townsend Freeman
Dept. of Anesthesia, Medical College of Georgia,
Augusta, Ga.
- William Jefferies Goudelock
71 Rogers St., S.E., Atlanta 17, Ga.
- Halcott Townes Haden
234 S. Colonial Homes Circle, N.W., Atlanta, Ga.
- Erving Douglas Hardy
36 Pleasant St., Worcester, Mass.
- Richard Bancroft Heilman
97 Sanderson St., N.E., Atlanta, Ga.
- Joe Bob Hilliard
2414 Central, Augusta, Ga.
- William Wilson Hodges
3110 Peachtree Dr., N.E., Atlanta 5, Ga.
- Edward Lewis Johnson
1416 Haygood Dr., N.E., Atlanta 7, Ga.
- Frederick Boone Jones
c/o Decatur Clinic, 231 East Ponce de Leon Ave.,
Decatur, Ga.
- Edward Leon King
Battey State Hosp., Rome, Ga.
- Jack Marvin Levene
104 E. Taylor St., Savannah, Ga.
- Edgar Eugene McCanless
318 Avenue B. West, Barksdale AFB, La.
- Virginia Petway McNamara
1408 Rock Spring Circle, Atlanta, Ga.
- James Barry Minor
Butler, Ga.
- David Maclyn Nowell
Box 1138, Dalton, Ga.
- Horace Henry Osborne
2418 McDowell St., Augusta, Ga.
- Dewey Elman Overton
17 Prescott St., N.E., Atlanta, Ga.
- William Curtis Pearcy
1210½ 15th St., Augusta, Ga.
- Tom Daniel Raaen
Pathology, Grady Hosp., Atlanta 3, Ga.
- Charles Jackson Ray
408 McCallie Ave., Chattanooga, Tenn.
- Russell Perry Reynolds
215 S. Randolph St., Garrett, Ind.
- John Sandberg
1708 Bailey Rd., Cuyahoga Falls, Ohio
- James D. Schuler
Watkins Memorial Hosp., Ellijay, Ga.
- Howard Marvin Sigal
259 Locust St., Akron 2, Ohio
- Hiram Maxwell Sturm
128 Ft. Washington Ave., New York 32, N. Y.
- Fred Louis Vidal
679 Juniper St., N.E., Atlanta 8, Ga.
- William Ralph Vogler, Jr.
1339 Clairmont Circle, Decatur, Ga.
- John Robert Wakefield
c/o Dr. W. C. Mitchell, Mitchell Bldg., Smyrna, Ga.
- Shirley Zoe Walsh
47 West 75th St., New York 23, N. Y.
- Lillian Pearl Warnick
108 Crow Dr., Smyrna, Ga.
- Carl Hunt Wells
1642 San Marco Blvd., Jacksonville 7, Fla.
- Leila Hulbert Wells
1642 San Marco Blvd., Jacksonville 7, Fla.
- Julius Wenger
c/o Vet. Admin. Hosp., 5998 Peachtree Rd., N.E.,
Atlanta, Ga.
- Jesse Lee Williams, Jr.
D-1-D University Apts., Durham, N. C.
- Nancy Jane Wing
475 Mt. Paran Rd., N.W., Atlanta 5, Ga.
- Clayton Edward Wood
3614 N. Audubon Rd., Indianapolis 18, Ind.
- William Martin Wyatt
2954 Thornwood Dr., Macon, Ga.
- Charles Tindal Young
c/o Dr. F. M. Young, Box 205, Athens, Ga.

IT'S TOO EASY TO BELONG TO A MEDICAL SOCIETY

W. BRUCE SCHAEFER, M.D., Toccoa, Georgia

IT HAS OCCURRED TO ME that perhaps membership in organized medicine is too easily obtainable.

When a physician becomes a member of his local medical society, he is thereby entitled to certain privileges for a lifetime; to practice and enjoy the privileges and *protection* of an organization whose history is replete with sacrifice, and whose glory is its constant endeavor to improve services to mankind.

What does the average man in medicine give in return for the privileges of membership in this great and honorable profession? Unfortunately the only obligations assumed by a young doctor on election to his society are ethical conduct and payment of dues.

These remarks are not intended to point a finger at anyone; on the contrary they are to call attention to the fact that preservation of the rights of the profession and the advancement of scientific treatment constitute a problem that needs and deserves the *active participation of every member*.

One often hears the remark, "I don't attend my society meetings because they are run by the old crowd, so what's the use?" This "same old crowd" probably runs the society because no one else will take the time or go to the trouble to attend the meetings. Mistakes are made, of course, but the members in charge are doing the best they can under the circumstances. The *only* way of influencing the actions of your society is by attending meetings and expressing yourself on all matters concerning the profession.

As you know, membership in the local society is a prerequisite to membership in state and national associations, membership in specialty groups, and on hospital staffs. It is obvious, then, that if membership is so eagerly sought after in the higher



president's letter

echelons of medicine, then the attainment of membership in the local society should not be so lightly taken as it is by some of our fellows.

I wonder if some of the following proposals might be remedial, or at least stimulating, to some of our delinquent members.

1. The minimum requirement for renewal of membership in the local society at yearly intervals should be attendance at, at least one-third of the stated meetings of that society.

2. Acquirement of membership on the active staff of at least one hospital, local conditions permitting.

3. A committee on attendance should be appointed by local societies to do the following:

- A. Telephone members and urge them to attend.

- B. Make personal calls on delinquent members.

- C. Have the president write special letters to the delinquent members, encouraging them to participate. (We could take a tip from the Rotary Club, which does not tolerate lax attendance.)

The society program committee should encourage young members, particularly those of reticent or timid personality, to write a paper or speak at meetings.

It seems evident that a longer probation period, possibly one year with courtesy privileges, should be a prerequisite to local society membership. During this period, the candidate should be required to attend at least three-fourths of all stated meetings, as evidence of good faith and to acquaint himself with the personnel and procedures of the society.

It is trite but true, absolutely true, that medical organizations, just as all other bodies, are only as strong as their weak links. May I leave this conclusion for your consideration: Doctors must pay with far more than just dues if they are going to be useful members of their societies. They must *serve*.

Bruce Schaefer



abstracts by georgia authors

reported before the Section on Laryngology, Otology and Rhinology of the A. M. A. in Chicago last June.

Bryant, Milton F., M.D., 1211 West Peachtree St., N.E., Atlanta. "Surgical Treatment of Segmental Arteriosclerotic Lesions of the Terminal Aorta and Peripheral Arteries", *Bulletin of the Fulton County Medical Society* 31:17-22 (May 3) 1957.

In the past decade marked progress has been made in the treatment of segmental arteriosclerotic lesions of the terminal aorta and peripheral arteries. These arteriosclerotic lesions occur predominantly in men between the ages of 40 and 70, and due to the numerical increase of our older population, the total number of patients with arteriosclerosis and its complications is rapidly increasing. Patients with arteriosclerosis may develop aneurysms or obstructive lesions in the terminal aorta and arteries of the lower extremities. These lesions are frequently segmental in nature and may be amenable to direct surgical correction. Aneurysms are preferably treated by excision and graft-replacement. Patients with segmental arteriosclerosis obliterans should be evaluated carefully, frequently with arteriograms, as it may be possible to restore the blood flow to normal by direct arterial surgery. Short segmental occlusions in the abdominal aorta and proximal iliac arteries may be treated by extirpation of the occluded area and restoration of arterial continuity with a graft. The by-pass shunt procedure is at present the procedure of choice for segmental occlusion in the distal iliac and femoral arteries.

Crow, Horace E.; Coleman T. King; C. Edwin Smith; Raymond F. Corpe; and Ingrid Stergus, Battey State Hospital, Rome, Ga. "A Limited Clinical, Pathologic and Epidemiologic Study of Patients with Pulmonary Lesions Associated with Atypical Acid-fast Bacilli in the Sputum", *Am. Rev. Tuberc.* 75:199-222 (Feb.) 1957.

There were 69 such cases studied and treated at Battey Hospital between 1950 through August 1955. Of the 69, 65 consistently showed atypical bacilli. These organisms were distinguished from *M. tuberculosis* by their cultural characteristics and their predominant avirulence to the guinea pig. Of the 69 strains 64 showed smooth, buff colored, slow growing, and predominantly nonphotochromogenic cultures; three were chromogenic; and two were rough, rapidly growing. The majority of strains showed partial to complete pre-treatment resistance to Isoniazid. Apparently no patient had acquired his infection from an Isoniazid-treated patient. Most patients had roentgenograms simulating tuberculosis. Only 17 per cent were under the age of 40. Only 58 per cent reacted to .01 O.T.; incidence of infection was low in the Negro; the spouses of 63 married patients were negative for tuberculosis; no contact cases were discovered.

Grossly and microscopically, surgical specimens were indistinguishable from tuberculosis. Response to chemotherapy, poor; to surgery, fair.

Fourteen patients worsened, five of whom died of progressive disease. These

Lewis, John R. Jr., 478 Peachtree St., N.E., Atlanta 8, Ga. "The Thigh Lift", *J. Internat. Coll. Surgeons* 27:330-334 (Feb) 1957.

With the modern realization by physicians of the importance of reducing the excessively overweight patient, the plastic surgeon sees more frequently those with great relaxation of the facial and bodily tissues, including the facial and neck tissues, breast tissues, the pendulous abdomen, and the relaxed pendulous thigh tissues. To the armamentaria of surgery for these other areas, the "thigh lift" has been devised to solve the problem of the redundant and relaxed skin and subcutaneous skin of the thighs. The technique involves an oblique incision starting at the anterior iliac spine, crossing the inguinal region anteriorly, and going down the posteromedial aspect of the thigh to a point just above the knee. A large wedge of fatty tissue and skin is excised, and the tissue is pulled together circumferentially and the redundant drooping tissue is anchored superiorly. This tightens the tissues about the thigh and also eradicates the droop. Patients may wear bathing suits and shorts following this procedure without the incision's being obvious, and with a very noticeable improvement in the appearance of the thighs. The increased comfort of the patient should not be overlooked, and the convenience of fitting clothes is itself not a minor factor. However, the patient's self confidence and improved mental outlook after the operation outweigh these other factors.

Edwards, Betty F., and Gray, Stephen W., Department of Anatomy, Emory University. "Growth, work output and sensitivity to increased gravitational forces in wheat coleoptiles", *J. Cell. & Comp. Physiol.* 48:405-420 (December) 1956.

Increased gravitational forces from 10 to 500 times gravity have been shown to reduce the height of growing plants, (Gray and Edwards '55). In this paper, the relative sensitivity of different portions of the growth period to such forces is determined.

Sanford winter wheat seedlings were grown in the dark on sterile sand without nutriment. Supra-gravitational forces were produced by centrifugation.

Applied for the first day only, centrifugation produced stimulation of growth. Similar forces applied on each of the other three days of the growing period produced inhibition of growth. In each case, the effect lasted for 24 hours after the experimental force was removed.

Coleoptile diameter and cell diameter increased with centrifugation on any of the four days of growth, the effect becoming greater on each successive day. Root growth rate also was reduced during last three days, the effect increasing with each day of exposure.

It is concluded that these effects are the result of placing an intolerable work load upon the growing tissue. On the first day the added physical work of growing upward is relatively small, but on the other three days it increases tremendously, reaching a maximum work peak on the third day of growth.

Equen, Murdock; George Roach; Robert Brown; and Truett Bennett, 144 Ponce de Leon Ave., N.E., Atlanta 8, Ga. "Nail Removed from Duodenum with Intraluminal and Extracorporeal Magnets", *Arch. Otolaryngology* 65:374-76 (April) 1957.

Ten years ago Equen saw a child of four who had harbored a large nail in his duodenum three weeks. He had him swallow a magnet attached to a string, and, when contact had been established, under fluoroscopic guidance he recovered nail and magnet through the stomach, esophagus, and mouth. He claimed that this was the first time a foreign body had been removed from the duodenum from above, and this claim has not been disputed, not even by the Russians. The child was in the hospital three days, and he was spared an open operation with intravenous feedings and a more prolonged period of hospitalization.

The Ponce de Leon Infirmary group was equally successful in a number of similar cases, but finally they encountered an infant in whom the ordinary Equen magnet failed to budge the nail. The application of a large Alnico magnet on each side of the little boy's body so increased the power of the magnetic field that by gentle traction on the string they were able to retrieve this nail also. The paper was

organisms obviously are pathogenic to man, but probably less communicable than *M. tuberculosis*, as 71 per cent of contacts of 51 patients were negative to .01 O.T.

Whitaker, Carl A., 1293 Peachtree St. N.E., Atlanta 9, Ga. "Communication in Brief Psychotherapy with the Non-Psychotic Patient"; *Dis. Nerv. System* 18:67-72 (Feb.) 1957.

A central problem in the field of psychotherapy is the problem of communication between doctor and patient. For years, psychiatry put major emphasis on the understanding of the patient. First his background story, later his behavior, still later with Freud and the discovery of free association, we began to interpret the signals sent by the patient in a more comprehensive way. The data accumulated and the complex language is such that even psychiatrists are sometimes hard put to understand their meanings. The process of psychotherapy may at times consist of teaching the patient this technical language which may not get him better. Dr. Reusch has said that the better the communication the better the treatment. The simultaneous use of two therapists is one method of increasing the communication from the therapist to the patient so that the patient can hear the two more clearly. It is an intermediate type of communication and increases the non-verbal aspects of communication with the patient. The method is illustrated in the paper by the description of fantasies and dreams; a picture language which helps to bridge the gap from simple conversation to full scale communication between the doctor and the patient. The patient can present in the therapeutic hour the pictures which flash on his mind, and the therapist can present to the patient the pictures and associations which flash on his mind during the interview setting.

In summary then, verbal scientific language helps the psychiatrist to understand the sickness, but we need a way to increase the non-verbal communication, and one way is to use word pictures to paint fantasies and dreams of the patient and of the therapist. The use of this method is based upon the concept that such fantasies and such word pictures do carry significance and are valuable in the communication between the doctor and the patient.

Harrison, Capt. J. Harold (MC), U. S. Army; Swanson, Davis S., M.S., Denver; and Lincoln, Lt. Col. Arthur F. (MC), U. S., Army. "A Comparison on the Tissue Reactions to Plastic Materials", *A.M.A. Arch. Surg.* 74: 139-144 (January) 1957.

The study was done in experimental animals to compare the tissue reaction to the plastics that are being used in surgery. When used in small amounts such as sutures, the difference in reaction might not become apparent, but when larger quantities are used, such as in the replacement of tissue defects and artery grafts, this factor is multiplied and might well influence the outcome.

In the overall comparison there was

a marked difference in the response of the host to nylon and "Teflon." Of the plastics studied, nylon caused the most inflammatory reaction and "Teflon" the least. There was an intermediate degree of reaction to "Dacron," "Polyvinyl" sponge, and "Orlon" in that order. Silk caused more reaction, both acute and chronic.

The degree of reaction was correlated with the chemical and physical properties of the plastics.

It was concluded that from the standpoint of tissue reaction, "Teflon" is a most desirable synthetic material for use in surgery. It should be useful as T-tubes, drains, artery grafts, and in replacing bone and fascial defects where its inertness will be beneficial.

Harrison, J. Harold, 69 Butler St., S.E., Atlanta 3, Ga. "The Use of Teflon as a Blood Vessel Replacement in Experimental Animals", *Surg., Gynec. & Obstet.* 104:81-87 (Jan.) 1957.

"Teflon" is chemically the most inert plastic known, is practically non-wettable, and incites minimal tissue reactions. For these reasons it was included in a comparative study of the synthetic materials as vascular prostheses. Grafts of the material were inserted in large and small arteries of 60 dogs.

The results in over 250 grafts indicated that it was superior to "Dacron," "Orlon," nylon or "Ivalon" sponge. The incidence of occlusion from thrombosis when replacing small vessels (less than nine mm. in diameter) was lower and compared favorably with homografts. It lost no strength during the one year period of the study, and from its chemical inertness would be expected to lose little strength after longer periods of time.

The results were, as with the other materials studied, unsatisfactory when vessels less than five mm. in diameter were replaced.

The limitations, disadvantages, and technical problems in the use of "Teflon" as a blood graft were discussed.

Harrison, J. Harold, and Adler, Richard H., 69 Butler St., S.E., Atlanta 3, Ga. "Nylon as a Vascular Prosthesis in Experimental Animals with Tensile Strength Studies", *Surg., Gynec. & Obstet.* 103:613-617 (Nov.) 1956.

As a part of a comparative study of the synthetic materials as vascular prostheses, grafts of nylon were inserted in the thoracic aorta of 28 dogs. Since maintenance of patency is no problem in grafts this size, the study was done to determine if the material would maintain its strength after implantation as an artery graft to prevent aneurysm and rupture.

It was found that nylon lost 80 per cent of its original strength by six to 18 months, and one of the grafts ruptured at 24 months, indicating a complete loss of strength.

The loss of strength of a synthetic material after implantation in the body is due primarily to chemical degradation. This was correlated with the relative chemical instability of nylon.

It was concluded that nylon, because of this loss of strength after implantation, is unsatisfactory as a vascular prosthesis.

Brown, Lester A., M.D., 490 Peachtree St., N.E., Atlanta, Ga. "Acoustic Accident", *Laryngoscope* 67:238-245 (March) 1957.

Acoustic accident in the condition in which one ear (bilateral has not been seen by this author) suddenly becomes deafened, with or without the side symptoms of nausea, vomiting, and vertigo. Deafness is virtually complete in the affected ear within a matter of hours, the exception being prolonged up to three weeks. Academically, there may be some useless hearing residual.

The cause is not known. There are no positive related findings, except the labyrinthine.

Most common first indicator of deafness is the telephone. Where there had not been any telephone hearing problem, now there is no sound, and the victim considers the phone to be out of order. The female has priority two to one. The 40-50 age group is largest.

There is no positive treatment. Sedatives, antiseasick medicaments, and intravenous fluids constitute the immediate treatment for distressing symptoms. Anticoagulants are indicated where the diagnosis is made the first day. Some nicotinic containing compound such as Vastran forms the basis of later therapy.

Continued unilateral deafness is expected; partial hearing return is rare; complete return would point to a mistaken diagnosis.

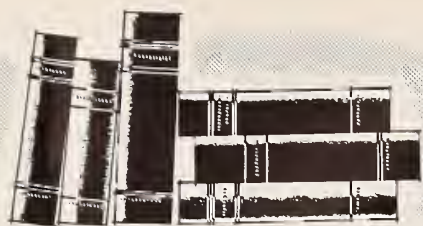
Georg, Lucille K. Ph.D., Eugene A. Hand and Robert A. Menges (DVM), C.D.C., U. S. Dept. Pub. Health, Atlanta, Ga., "Observations on Rural and Urban Ringworm," *J. Invest. Dermat.* 27:335-353 (Nov.) 1956.

A comparative study of urban and rural ringworm as seen in Northeastern Michigan has been presented. In general rural ringworm is of animal origin, the two etiologic agents are *Trichophyton verrucosum* and *T. mentagrophytes* (granular variety). *T. verrucosum* infections are directly related to contacts with ringworm infected cattle. Rural, *T. mentagrophytes* infections probably result from direct or indirect contacts with a wide variety of animals. The role of rodents as reservoirs and possible agents of transmission of *T. mentagrophytes* ringworm is discussed.

Urban ringworm is divided between human epidemic types caused by *Microsporum audouinii* and *T. tonsurans*; and infections contracted from cats and dogs, largely due to *M. canis*. Ringworm due to *T. tonsurans*, which had been previously unknown in this area, has become endemic in sections where Latin-American communities have developed.

Hobbs, A. C., Jr., M.D., 213-215 Martin Bldg., Columbus, Ga. "Osteoma of the Orbit: Report of a Case", *Am. J. Ophth.*, 43: 615-617 (April) 1957.

This case of osteoma in a colored female aged 48 arising from the right ethmoidal bone is presented. The author reviews the literature used in removal of the new growth.



physician's bookshelf

BOOKS RECEIVED

Atkinson, D. T., M.D., *MAGIC, MYTH AND MEDICINE*, The World Publishing Company, Cleveland and New York, 1956, 307 pp., \$5.00.

de Kruif, Paul, *A MAN AGAINST INSANITY*, Harcourt, Brace and Company, New York, 1957, 238 pp., \$3.95.

Beck, William S., *MODERN SCIENCE AND THE NATURE OF LIFE*, Harcourt, Brace and Company, New York, 1957, 287 pp., \$5.75.

Equen, Murdock, M.D., *MAGNETIC REMOVAL OF FOREIGN BODIES*, Charles C. Thomas, Publisher, Springfield, Illinois, 1957, 92 pp., \$4.50.

Williams, Glanville, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW*, Alfred A. Knopf, New York, 1957, 350 pp., \$5.00.

Graves, Robert, *THEY HANGED MY SAINTLY BILLY*, Doubleday and Company, Inc., Garden City, New York, 1957, 312 pp., \$3.95.

Wolstenholme, G. E. W., and Millar, Elaine, C. P., *REGULATION AND MODE OF ACTION OF THYROID HORMONES*, Ciba Foundation Colloquia on Endocrinology, Vol. X; Little, Brown and Company, Boston, 1957, 303 pp., 114 ill., \$8.50.

Wolstenholme, G. E. W., and O'Connor, Cecilia M., *THE CHEMISTRY AND BIOLOGY OF PURINES*, Ciba Foundation Symposium; Little, Brown and Company, Boston, 1957, 317 pp., \$9.00.

Pullen, Roscoe L., M.D., *PULMONARY DISEASES*, Lea and Febiger, Philadelphia, 1955, 669 pp., 195 ill., \$15.00.

Bettman, Otto L., *A PICTORIAL HISTORY OF MEDICINE*, Charles C. Thomas, Publisher, Springfield, Illinois, 1956, 307 pp., \$9.50.

Massie, William A., *MEDICAL SERVICES FOR RURAL AREAS, THE TENNESSEE MEDICAL FOUNDATION*, Harvard University Press, Cambridge, Massachusetts, 1957, 68 pp., \$1.25.

Reich, Walter J., and Nechtow, Mitchell J., *PRACTICAL GYNECOLOGY*, 2nd Edition, J. B. Lippincott Company, Philadelphia, 1957, 623 pp., \$12.50.

Farris, Edmond J., Ph.D., *HUMAN OVULATION AND FERTILITY*, J. B. Lippincott Company, Philadelphia, 1956, 148 pp., \$6.50.

Liebman, Samuel, M.D., *MANAGEMENT OF EMOTIONAL PROBLEMS IN MEDICAL PRACTICE*, J. B. Lippincott Company, Philadelphia, 1956, 146 pp., \$5.00.

Hilliard, Marion, M.D., *A WOMAN DOCTOR LOOKS AT LOVE AND LIFE*, Doubleday and Company, Inc., Garden City, New York, 1957, 181 pp.

Leopold, Simon S., M.D., *PHYSICAL DIAGNOSIS*, W. B. Saunders Company, Philadelphia, 1957, 537 pp., 379 ill., \$9.00.

Adler, Francis Heed, M.D., *GIFFORD'S TEXTBOOK OF OPHTHALMOLOGY*, W. B. Saunders Company, Philadelphia, 1957, 499 pp., \$8.00.

Williams, Marian, Ph.D., and Worthingham, Catherine, Ph.D., *THERAPEUTIC EXERCISE*, W. B. Saunders Company, Philadelphia, 1957, 127 pp., \$3.50.

Robbins, Stanley L., M.D., *TEXTBOOK OF PATHOLOGY WITH CLINICAL APPLICATIONS*, W. B. Saunders Company, Philadelphia, 1957, 1351 pp., 933 figs., \$18.00.

Chase, Francine, *A VISIT TO THE HOSPITAL*, Grossett and Dunlap, Inc., New York, 1957, 68 pp., \$1.50.

Langer, Marion, Ph.D., *LEARNING TO LIVE AS A WIDOW*, Gilbert Press, Inc., distributed by Julian Messner, Inc., New York, 1957, 255 pp., \$3.95.

REVIEWS

Ham, Thomas Hale, B.S., M.D., *A SYLLABUS OF LABORATORY EXAMINATIONS IN CLINICAL DIAGNOSIS*, Harvard University Press, Cambridge, 1956, 496 pp.

This *Syllabus* was written to be used as a textbook in the author's course in clinical pathology for second year students in Harvard Medical School. This is the sixth printing of the book which has not been revised since 1950. Many famous names are listed as contributors, and there is a long list of outstanding critics. The book exudes the flavor of Harvard University, Massachusetts General Hospital, Boston City Hospital, and New England Medicine. The editor states that the *Syllabus* is intended to be a critical evaluation of laboratory procedures in the study of the patient. Thus, it is intended primarily to teach medical students to evaluate laboratory data. It is apparently intended to be used in teaching how to make a clinical diagnosis and is therefore much more suitable for training clinical pathologists than for training technicians. There is far more emphasis on critique than on technique. This would seem to be a realistic approach, since laboratory examinations are seldom done by the physician himself. The principle involved in various tests is discussed in the text in most cases, but the reader is frequently referred to books or articles for instruction in the technique.

The *Syllabus* begins appropriately with a scholarly discussion of units of measurement. The author makes a strong argument for abandoning the expression "Mg. %" in favor of Mg/100 ml. The *Syllabus* contains some valuable tables of normal values as originally published by Mallory, Castleman, and Parris in the *New England Journal of Medicine*.

Since the book is at least six years old, there is no mention of such subjects as L. E. cells, C-reactive protein, Goffman particles, or paper electrophoresis. Although the book could stand a revision, it is still quite valuable for several reasons including the excellent references to original articles describing tests and their evaluation.

An interesting and worthwhile feature is a section on the cost of laboratory examinations. In this chapter the fees charged for various tests in several representative hospitals are listed. There is also a list of the costs of various pieces of laboratory equipment and supplies. It seems quite realistic to include such a chapter because physicians have to deal with the economic aspects of arriving at a diagnosis.

One criticism this reviewer must make is that it is very difficult to locate information in the index. For example, I was unable to find in the index any references to the technique for determining serum bilirubin. I also noted that there is no mention of micro methods for various blood chemical analyses, an omission which will make the book unpopular with pediatricians.

The section on the evaluation of clinical data is very good. There is also a good section on the technique of collection of blood samples. A defect is the lack of illustrations throughout the book. Their absence makes

it necessary to use the book with its companion volume (a color atlas) by Geneva A. Daland.

Anyone planning to use this syllabus as a "cook book" for doing laboratory tests will be disappointed. Those wishing to use it as a source of excellent references to authoritative works will be pleased.

Some sections of the book are rather sketchy as, for example, the bacteriology section where the reader is frequently instructed that the choice of culture media should be left to the bacteriologist. This, however, is understandable since the subject of bacteriology could fill a book larger than the present one.

This reviewer noted with interest that the editor recommends that the blood sugar specimen for diagnosis of diabetes mellitus be taken three hours after a breakfast of 100 grams of carbohydrate. The dextrose tolerance test was described as a three-hour test in which the highest level of the blood sugar is 150 mg. per 100 ml. and the normal fasting level is reached within three hours. It seemed that there was not sufficient discussion of the interpretation for clinical purposes.

This book has the advantage of being published in a very inexpensive format. It has the usual disadvantages of a syllabus and is more valuable as a textbook for the author's courses than for any other purpose.

Arthur M. Knight, Jr., M.D.

Wolstenholme, G. E. W., and O'Connor, Cecilia M., BONE STRUCTURE AND METABOLISM, Ciba Foundation Symposium; Little, Brown and Company, Boston, 1956, 229 pp., \$8.00.

This book consists of papers presented at a symposium sponsored by the Ciba Foundation, held in London in July 1955. Attending and participating in this symposium were some 28 physicians and scientists largely from Western Europe and North America, interested in the chemistry, biology, embryology, and clinical problems related to bone structure and metabolism.

The book itself consists of the 20 papers presented by this group with discussion by the members of the symposium. The papers themselves include research studies on anatomical and molecular structure of bone, research on the chemical constituents, metabolic studies, and, finally, related experimental bone diseases and clinical states. Recent techniques of analysis are presented; these include studies comparing microscopic pictures with micro-radiograms and radio-autographs. This last is a new technique involving microscopic pictures made by tissue sections of radio-active bone on appropriate photographic plates. When certain elements are replaced with radio-active isotopes prior to death, the resulting bone sections can be studied by the pictures such isotopes leave on suitable film. These radio-autographs form an additional method of chemical analysis which can be correlated with microscopic radiographs and tissue sections.

These and numerous other techniques, together with refinement of metabolic analysis, enable the diligent reader to get a rather excellent overall picture of the newer trends of study in twenty-odd institutions of learning on the problem of bone and bone metabolism.

This book is not to be recommended for the general practitioner in search of a solution to a clinical problem. In most of its parts the scientific points made by the authors will elude the casual reader, and

indeed the average physician will have to recall a considerable amount of his basic science training to follow even laboriously much of the thinking presented. Most of the papers in this symposium would be of interest to the research anatomist or physiologist or clinical investigator. Despite the fact that it is interesting to briefly read and dwell on some of the interesting new techniques employed, this book is not recommended for a light afternoon reading. Nevertheless, as an up to date reference for the student interested in a review of current studies on bone anatomy and physiology and related metabolic problems, this book should be a valuable resume.

F. James Funk, Jr., M.D.

Nadas, Alexander S., M.D., PEDIATRIC CARDIOLOGY, W. B. Saunders Company, Philadelphia, 1957, 587 pp., 343 figs., \$12.00.

The long dormant optimism of a few interested pediatricians in the field of cardiology within their specialty was vindicated in the past decade by the operative intervention of Blalock in the Tetralogy of Fallot, based upon the careful studies and observations of Taussig, and by the dramatic technical skill of Gross and others in coping with coarctation, patent ductus, and septal defects. Advances in vascular surgery swiftly made feasible undreamed of feats of surgery and rendered a sizeable segment of an otherwise doomed group of patients either normal or remarkably improved.

It is not surprising then, that the field of pediatric cardiology has burgeoned from a dismal and adynamic cataloguing of signs and symptoms, longevity prospects, and shopworn clinical aphorisms into the bustling, exciting, and progressive circumstances of present day pediatric medicine. The need for a comprehensive text embodying all of the aspects of this field has long been evident to those who practice pediatrics.

Alexander Nadas brings to pediatric cardiology a background in practical pediatrics which is unique among those in his specialty. Alert to the problems of the patient as well as of his heart, his approach to therapy is deft and sound, with emphasis upon the peculiar reactivity and problems of the infant and child, and a profound understanding of the resilience and idiosyncrasies of their vascular apparatus.

The book deals with all of the aspects of pediatric cardiology, including in its scope the experience gathered at the cardiovascular clinic at the Children's Medical Center in Boston. This active clinical group has analyzed and correlated the signs and symptoms, laboratory and catheterization findings, phonocardiographic and roentgenographic studies, including angiocardiology, of all forms of cardiac disease peculiar to this age group, both congenital and acquired. The range of their material has allowed them to arrive at conclusions based upon observed fact, rather than upon tradition.

The chapters on acquired heart disease are a welcome compilation of a number of papers published by this group over the past years. Experiences with rheumatic heart disease, as observed at the Good Samaritan Hospital, and with arrhythmias and myocarditis, as observed in the in-patients at Children's Medical Center, are discussed in detail, with advice as to therapy, prognosis, and pathophysiology.

The section on therapy, directed as it is to the pediatric age group, brings out a number of worthwhile and useful clinical signposts for evaluating and managing

ing the pediatric patient. It is refreshing to hear these words of advice from a pediatrician. The trend of past years, occasioned by the disinterest and ignorance of many pediatric groups to make pediatric cardiology a Lilliputian facet of internal medicine, has created problems for patients and pediatricians alike. The attitude and advice of Dr. Nadas and his group should be a rousing stimulus to pediatricians to widen their scope, and to bring to the field of cardiology the acumen and understanding which presently characterizes the field of fluids and electrolytes.

The coming generation of pediatricians will perforce become facile in the field of cardiology; to them, and to those interested or trained in the field during their pediatric residencies or practice, this text will long be an authoritarian reference and aide.

Sanford J. Matthews, M.D.

Exner, F. B., M.D.; G. L. Waldbott, M.D.; and James Rorty (Editor), *THE AMERICAN FLUORIDATION EXPERIMENT*, Devin-Adair Company, New York, 1957, 264 pp., \$3.75.

Actually this book is fiction and should be regarded only as interesting reading by members of the scientific profession and not used as a guide or reference.

The controversy over fluoridation of public water supplies has been brought about by food faddists, publicity seekers, and a few religious groups closely associated with a large segment of the population who can be easily influenced to believe that the physicians, the dentists, and public health officers have a deliberate desire to heap upon them infirmities and crippling conditions that will plague them throughout life.

The two authors have already been subject to what would be complete humiliation to most conscientious professional people but seem to wish to be subjected to such embarrassment. As an example, Exner went so far as to sue the Chehalis (Washington) Fluoridation League for \$1,000 offered to anyone proving that one part per million of fluoride in a water supply would be detrimental to health. Even though Exner lost, he gained great favor from the anti-fluoridationists throughout the country and no doubt embarrassed his profession by such public demonstrations. On the other hand, Dr. G. L. Waldbott, whose wife is the editor of "National Fluoridation News," has gained his place as a leader against fluoridation by contributing numerous articles to this paper as well as making public appearances opposing fluoridation, using every device to influence lay people to oppose and question the integrity of all health professions who have studied the subject and endorsed its use. He has also been criticized for diagnosing "fluoride poisoning" by mail. James Rorty, Editor of *The American Fluoridation Experiment* has perhaps gained more national recognition by writing an article in *Harper's Magazine* entitled, "Go Slow on Fluoridation," than he would have ever

received from any other source. He has been an opportunist who has helped poison the minds of numerous individuals, causing them to question the sincerity of the health professions.

The two physicians and the editor, in the opinion of this reviewer, have done more to slander the health profession in the eyes of the unthinking public than any force in the past decade. Rorty, the editor, starts out in the introduction by discussing the random treatment for the whole population with dangerous drugs known to be cumulative and attempts to frighten the unscientific public into further reading of this trash. He uses such terms as *minute quantities*, *accumulation*, *poisonous*, *mass medication*, *experimental*, and later takes off on the investigators who give fluorine (not fluorides) credit for the good teeth. He places much more importance on the Congressional hearings and big talk by publicity seekers than the scientific results observed in various projects that were carefully carried out by some of the most reliable scientists in our country.

The editor's attack on the U. S. Public Health Service is almost libelous and if done or said about an individual practitioner would perhaps be brought into courts as defamation of character. His views about the American Dental Association and the American Medical Association are almost as critical. The authors and editor infer that all statistical data has been twisted and slanted to favor fluoridation and that anyone showing fluoride results evidently had to juggle his statistics to show the desired results.

Throughout the book the authors have attacked as erroneous and misleading the studies that have shown fluoridation in the recommended amounts to be beneficial, both natural and controlled. A further attack is made upon the individuals or persons conducting these studies. On the other hand, they accept random statements from foreign countries, or work done by individuals using excessive amounts of fluorides in their reports. None of the arguments against fluoridation are new to those who have been working in this field. Up to this time, statements made as to adverse results occurring with fluoridated water that is properly controlled can be or have been refuted with scientific facts.

In no instances did the authors show conducted studies upon controlled groups in order to establish so-called presence of certain physiological conditions as occurring only in fluoridated areas.

It is amazing to see the numerous physical conditions these two physicians attribute to fluoride poisoning. If fluorides are the cause of all the diseases and conditions they suggest, practically all the medical problems can be solved by eliminating the chemical from our water and perhaps diets. Individual testimonials and opinions are accepted in lieu of scientific studies.

After reading this book, I am thoroughly in agreement with the person who said about the opponents of fluoridation, "Don't confuse me with the facts—my mind is made up."

Anyone who accepts *The American Fluoridation Experiment* as a statement of fact or allows himself to be influenced by Drs. Exner and Waldbott and Editor Rorty is either not capable or unwilling to evaluate scientific evidence.

T. F. Sellers, M.D.

This volume covers considerably more topics than the title might lead one to suspect. Ten papers which are edited from the Cushny Memorial Lectures, which were delivered at the University College, London, are presented. The contributors include most of the well known names in British medicine who have been active in the investigation of many varied aspects of the kidney in health and disease (Eggleton, Bayliss, McCance, Bull and others).

The first five chapters are composed of material which is of major concern to those who are interested in measuring and understanding the physiological mechanisms of kidney function. The last five chapters are worth the price of the book to the average practicing physician interested in some of the newer and more unusual aspects of the advancing medical frontier. Included among these is a rather comprehensive discussion of the adrenal cortex and the effect of its hormones on renal function. This chapter considers individually each of the natural as well as the synthetic hormones which the drug houses are continually pushing under our doors. Renal function in Addison's disease is adequately discussed in a concise manner.

Presented under the heading of genetic aspects of tubular function are the perplexing familial conditions cystinuria, galactosaemia, Wilson's disease, Hartnup's disease, and the Fanconi syndrome. I know of no other one place where as much diversified, yet compact, information can be found on these unusual subjects.

A chapter on metabolism and renal function in the first two days of life reports the finding in studies which should interest the pediatrician.

Chapter Nine discusses the functional aspects of renal failure. Up to date concepts are presented in an easily read manner and will serve to reorient those who have not kept abreast with the recent rapidly changing ideas of renal function, particularly in the field of chronic renal disease. Chapter Ten compliments Chapter Nine with a discussion of the possibilities of osmotic diuresis in acute tubular necrosis (lower nephron nephrosis).

Characteristically true of British authors, the material is concisely presented throughout the book. There is an adequate index and an excellent bibliography. Perhaps the most refreshing thing about these papers is that the reader learns what the writers themselves think rather than getting a rehash of the literature.

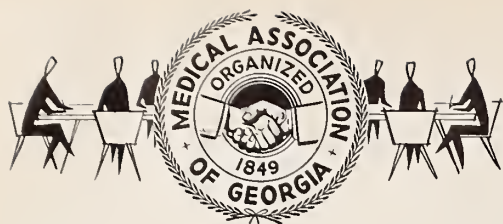
Charles L. Whisnant, M.D.

AMEF Contributions

IN FEBRUARY of this year, the American Medical Education Foundation distributed grants to the country's 83 medical schools. The total amount granted was \$1,072,727.00; of this, the Medical College of Georgia received \$8,509.00, and the Emory University School of Medicine received \$8,433.00. Each year Georgia physicians are asked to contribute to the AMEF, and each year, so far, Georgia physicians have failed to reach the \$10,000 goal set by the AMEF Committee of the MAG. Many more are contributing each year, and all are asked to give. Each contribution may be earmarked for any medical school in the United States; Georgia contributions do not necessarily go to the Georgia schools.

Listed below are the contributors to the American Medical Education Foundation during the period November 1, 1956, through May 31, 1957, inclusive. Their total contribution was \$1,852.00. M. C. Adair, Washington; Cecil B. Elliott, Cedartown; Irving D. Hellenga, Toccoa; J. B. Stewart, Macon; Edward M. West, Atlanta; Neal F. Yeomans, Waycross; J. H. Arnold, Newnan; William E. Bellamy, Jr., Augusta; Dave Berman, Columbus; Paul L. Bradley, Dalton; Edmund A. Brannen, Macon; Henry A. Bridges, Bainbridge; Stewart D. Brown, Jr., Royston; Holmes G. Byrd, Athens; V. L. Darby, Vidalia; Marvin L. Davis, Atlanta; Hal M. Davison, Atlanta; W. B. Dillard, Cartersville; P. K. Dixon, Gainesville; W. L. Flesch, Waycross; L. M. Freedman, Savannah; Charles Freeman, Jr., Augusta; James A. Green, Athens; Tom Harbin, Rome; William P. Harbin, Jr., Rome; Milford B. Hatcher, Macon; Katrine R. Hawkins, Sylvania; Jasper T. Hogan, Macon; James T. Holt, Baxley; Jackson

Barrow Medical Society; G. F. Jones, Jr., Augusta; A. P. Keller, Jr., Athens; Ruskin King, Savannah; Ted F. Leigh, Emory University; Ken K. Looper, Canton; Robert Mainor, Smyrna; Frank R. Mann, Jr., McRae; John O. Martin, Macon; Milton Mazo, Savannah; Robert R. McKnight, Augusta; Joseph L. Rankin, Atlanta; T. E. Reeve, Jr., Carrollton; W. P. Rhyne, Albany; C. H. Richardson, Jr., Macon; Arthur G. Singer, Toccoa; Leo Smith, Waycross; D. S. Sowell, Pelham; J. B. Stewart, Macon; Cyrus H. Stoner, Atlanta; F. H. Thompson, Albany; J. C. Thoroughman, Atlanta; Henry H. Tift, Macon; Charles W. Westerfield, Savannah; Herbert S. Alden, Atlanta; W. C. Baxley, Blakely; Charles T. Brown, Guyton; James R. Paulk, Moultrie; Vilda Shuman, Waycross; T. J. Van Sant, Jr., Marietta; Stuart D. Brown, Jr., Royston; William L. Cousins, Atlanta; Lawton Q. Hair, Augusta; William P. Harbin, Jr., Rome; Spencer A. Kirkland, Atlanta; Thomas K. Lewis, Jr., Atlanta; B. A. McCrum, Gainesville; Harvey M. Newman, Gainesville; Oliver C. Pittman, Commerce; William L. Pomeroy, Waycross; B. L. Shackelford, Atlanat; Scott L. Tarplee, Atlanta; W. L. Bridges, Jr., Tifton; Sage Harper, Douglas; Thomas D. Johnson, Albany; Ted F. Leigh, Emory University; James J. McDonald, Athens; M. B. Slocumb, Atlanta; J. W. Daniel, Jr., Savannah; G. A. Hendrick, Perry; Charles W. Hock, Augusta; A. J. Kravtin, Columbus; T. C. McPherson, Atlanta; J. C. Metts, Savannah; M. E. Noel, Atlanta; N. W. Owensby, Atlanta; E. R. Pund, Augusta; L. J. Roberts, Columbus; E. K. Russell, Atlanta; W. P. Stoner, Sylvester; Thomas Brooks Medical Auxiliary; F. H. Thompson, Albany; Henry H. Tift, Macon; and J. S. Walker, Atlanta.



the association

COUNCIL OF THE M.A.G.

THE JUNE MEETING of the 1957-58 Council of the Medical Association of Georgia was called to order at 4:15 p.m. at the Dempsey Hotel, Macon, on June 15 by Chairman George R. Dillinger, Thomasville.

Present were W. Bruce Schaefer, Toccoa, President; Lee Howard, Sr., Savannah, President-Elect; Hal M. Davison, Atlanta, Immediate Past President; T. A. Peterson, Savannah, 1st Vice-President; Hugh Bickerstaff, Columbus, 2nd Vice-President; Chris J. McLoughlin, Atlanta, Secretary-Treasurer; Thomas W. Goodwin, Augusta, Speaker; and the following councilors: Charles T. Brown, Guyton, 1st District; George R. Dillinger, Thomasville, 2nd District; Luther H. Wolff, Columbus, Acting, 3rd District; J. G. McDaniel, Atlanta, 5th District; Charles S. Jones, Atlanta, 5th District Vice-Councilor; Henry H. Tift, Macon, 6th District; D. Lloyd Wood, Dalton, 7th District; F. G. Eldridge, Valdosta, 8th District; Paul T. Scoggins, Commerce, Acting, 9th District; Addison W. Simpson, Jr., Washington, 10th District; David R. Thomas, Jr., Augusta, 10th District Vice-Councilor. Also present were Charles H. Richardson, Sr., AMA Delegate; John L. Elliott, Savannah; Rudolph Bell, Thomasville; and Mr. John F. Kiser and Mr. Milton D. Krueger of the MAG Headquarters Office.

Following an invocation by Dr. Goodwin, the minutes of Council meetings of April 27 and May 1, and Executive Committee meeting minutes of May 1 were read by Mr. Kiser, and adopted on motion duly made and seconded.

AMA Delegates Report—Dr. Richardson presented the report of the AMA Delegates concerning the June 1957 New York meeting. He stressed the need for closer contact with the AMA and described in detail the various resolutions and reports acted on by the AMA House of Delegates. Dr. Richardson emphasized the need for greater support of the American Medical Education Foundation by the Medical Association of Georgia. He recommended that the Association appropriate funds for membership in the Conference of Presidents and Other Officers and in the Aces, Deuces and Treys Club. It was voted to approve dues payments to these organizations in the amount of \$150.00.

Meeting of Committee Chairmen—The recommendation of the 1957 House of Delegates requesting that Council hold a meeting of committee chairmen annually

to encourage committee activity was discussed. It was voted to hold such a meeting, the time to be set by the Executive Committee.

Student American Medical Association Appropriation—Dr. McDaniel discussed the instruction of the 1957 House of Delegates in regard to the appropriation of funds for one student from each of the two medical schools to attend the SAMA annual meeting. It was voted that this item be included in the budget for 1958.

MAG Distinguished Service Award—Dr. Dillinger discussed the recommendation of the 1957 House of Delegates that the Council establish a Medical Association of Georgia "Distinguished Service Award." Dr. Dillinger informed the Councilors that he would appoint a committee of three physicians to establish this award.

Memento for David Henry Poer—Dr. Schaefer discussed the recommendation of the 1957 House of Delegates that Council procure a suitable memento or trophy for David Henry Poer for his service as secretary-treasurer of the Association. Dr. Schaefer suggested that this memento be presented at the Fifth District Meeting in November.

Recommendations of First District Councilor—Dr. Howard and others discussed the recommendations of the 1957 House of Delegates which were part of the First District Councilor's report. On motion this matter was referred to the First District Councilor for study.

Social Security Discussion—Mr. Krueger and others discussed the 1957 House of Delegates recommendation that the MAG membership be polled in regard to Social Security inclusion for physicians. It was voted to poll the members as instructed by the House of Delegates. Dr. Dillinger informed the members that he would appoint a Tellers Committee in accordance with the House of Delegates instructions.

Medical Defense—Dr. McLoughlin discussed a legal fee for Mr. Dunaway in regard to defense of a malpractice case in the amount of \$1,395.00. Approval of payment of this bill was voted. Dr. McLoughlin reported on the final outcome of the *amicus curiae* brief filed with the Supreme Court in regard to a recent malpractice case.

Dr. McLoughlin read a statement from H. Dawson Allen, et al, in regard to medical defense dues apportionment. This information was accepted by Council. The statement follows:

"It is the opinion of the undersigned doctors, Allen, et al, that the Medical Association of Georgia is obligated to defend all cases of alleged malpractice to the court of last resort prior to the change in the Constitution and By-Laws as presently constituted since a portion of the dues have always been allocated for this purpose up to this time."

Special Legal Counsel Arrangements—Dr. McLoughlin presented a statement from Mr. Shackelford for study and advice relative to the practice of medicine during 1956-57 in accordance with 1956 House of Delegates instructions. It was voted to approve payment of this bill.

Dr. McLoughlin presented Mr. Shackelford's 1957-58 prospectus for study and advice relative to the 1957 House of Delegates request for MAG Legal Counsel to confer with the Board of Regents. It was voted to approve this prospectus and retain the Alston firm.

Dr. McLoughlin presented a request from the Richmond County Medical Society for assistance from Mr.

Shackelford in regard to their Constitution and By-Laws. It was voted to approve the request.

It was voted to include in the previous motion that this matter be covered by the retainer fee as stated in Mr. Shackelford's prospectus.

Dr. McLoughlin and others discussed, for information of Council members, the appeal submitted to the AMA Judicial Council by non-Richmond County Medical Society members.

Calhoun Lectureship Problem—Dr. McDaniel presented the following resolution:

"WHEREAS, at the present time the Citizens & Southern National Bank Trust Department acts as the trusteeship for the Abner Wellborn Calhoun Memorial Lectureship, and

"WHEREAS, this bank, as trustee, has paid direct to guest speakers each year an honorarium and/or expenses;

"WHEREAS, unexpended income (interest) according to the provisions of the trust must be added to the principle of the corpus, and

WHEREAS, it may be the custom for the Association to have this lectureship every two years, and

"WHEREAS, the trusteeship is authorized to make payments when directed to do so by the secretary-treasurer of the Medical Association of Georgia

"THEREFORE BE IT RESOLVED, that the Medical Association of Georgia hereby directs the Citizens & Southern National Bank to remit the interest of these funds annually to the Medical Association of Georgia for the purpose of paying the honorarium and/or expenses of a speaker or speakers at the annual meeting of the Association under the provisions of this lectureship fund at the direction of the secretary-treasurer."

It was voted to approve this resolution.

Life Membership Problem—Dr. McLoughlin discussed the administrative problem of Life Membership (now termed: Active-Dues Exempt No. 5) for clarification, and he pointed out that it was up to the Council to interpret the Constitution and By-Laws in regard to this matter. He suggested the following policy:

Clarification of "Life" Membership Classification Present Constitution and By-Laws now reads: "Chapter I, Section 4—Active, Dues Exempt (5): "... a member in good standing who is over 70 years of age ... this exemption to begin the year following the member's 70th birthday ... upon his application to the Association through his component county Society."

It is recommended this be construed to mean: "(1) A member is eligible for exemption in the first calendar year and thereafter following the year in which his 70th birthday occurs.

"(2) A member shall be considered in good standing provided that the requirements for good standing shall have been satisfied during the year in which his 70th birthday occurs.

"(3) Application for Life Membership from the member through his county society shall be considered evidence of his eligibility at any time after the January 1st which follows his 70th birthday, and such application, if approved, will void any

delinquency incurred during the calendar years after the member's 70th birthday."

It was voted to approve this policy in regard to Life Membership status.

VA Fee Schedule—Mr. Krueger presented information in regard to the Veterans Administration hometown care fee schedule which expires June 30, 1957. He pointed out that Dr. Joiner is in the process of completing a revision of the fee schedule and that the VA had asked for an extension to the present fee schedule for 60 days until contemplated re-negotiation can be effected and approved. It was voted to extend the present contract for 60 days.

It was voted that the Executive Committee would be empowered to negotiate a new contract with the Veterans Administration at the proper time.

The meeting was then recessed until Sunday morning at 8:30 a.m., June 16th.

CHAIRMAN DILLINGER called the reconvened June 15-16, 1957, meeting of the Council of the Medical Association of Georgia to order at 9 a.m., June 16, 1957, Dempsey Hotel, Macon.

Council members attending the June 15th recessed meeting were all present at this reconvened session June 16th. Also present was Charles W. Hock, Augusta, President, Richmond County Medical Society.

Appointment of Council Committees—Per the 1957 House of Delegates action the following Committees of Council were appointed by the Chairman:

MAG Committee Reorganization—W. G. Elliott, Cuthbert, Chairman; J. W. Chambers, LaGrange; and Thomas W. Goodwin, Augusta.

Cultists Committee—F. G. Eldridge, Valdosta, Chairman; Robert L. Brown, Emory University; Raymond F. Spanjer, Cedartown; and Albert M. Deal, Statesboro.

Councilor Apportionment and Redistricting—Thomas W. Goodwin, Augusta, Chairman; Maurice F. Arnold, Hawkinsville; and George T. Nicholson, Cornelia.

Standardization of Insurance Forms—Paul T. Scoggins, Commerce, Chairman; Joseph B. Mercer, Brunswick; W. L. Pomeroy, Waycross; and Robert E. Shiflet, Toccoa.

Tax Deduction for Indigent Care—John B. O'Neal, Elberton, Chairman; J. B. Neighbors, Athens; and Wesley W. Harris, Royston.

Other committees of Council appointed by the Chairman are as follows:

Institution-Physician Relations—F. G. Eldridge, Valdosta, Chairman; Stewart D. Brown, Jr., Royston; G. Darrell Ayer, Jr., Atlanta; and Lee Howard, Sr., Savannah.

Headquarters Building Committee—Chris J. McLoughlin, Atlanta, Chairman; Thomas J. Anderson, Atlanta; and Michael V. Murphy, Atlanta.

Annual Session Committee—Henry H. Tift, Macon, Chairman; Peter Hydrick, College Park, Commercial Exhibits; and Ted F. Leigh, Emory University, Scientific Exhibits and Meeting Rooms.

Unauthorized Practice of Medicine by Ancillary Personnel—A. M. Phillips, Macon, Chairman; Ralph W. Fowler, Marietta; and W. L. Pomeroy, Waycross

Social Security Tellers Committee—D. Lloyd Wood, Dalton, Chairman; A. W. Simpson, Jr., Washington; and Ralph W. Fowler, Marietta.

These committees and appointments were approved.

Appointment of Special Committees—The following MAG Special Committees were approved by Council and appointed by the President.

Medical Civil Preparedness—Edgar M. Dunstan, Atlanta, Chairman; Lee Battle, Rome; Perry P. Volpitta, Augusta; J. Fletcher Hanson, Macon; T. J. Ferrell, Waycross; Joseph S. Skobba, Atlanta; Charles E. Dowman, Atlanta; George M. Hutto, Columbus; and John L. Elliott, Savannah.

Blood Banks—G. Lester Forbes, Jr., Atlanta, Chairman; Lee Howard, Jr., Savannah; George B. Dowling, Atlanta; Walter L. Sheppard, Augusta; Hamil Murray, Gainesville; F. H. Thompson, Albany; and Frank Lewis Beckel, Columbus.

American Medical Education Foundation—Ben K. Looper, Canton, Chairman; J. Hubert Milford, Hartwell; Ruskin King, Savannah; H. Ansley Seaman, Waycross; W. E. Storey, Columbus; John Ridley, Atlanta; and Evelyn Swilling, Macon.

Crippled Children—J. C. Hughston, Columbus, Chairman; F. James Funk, Jr., Atlanta; John L. Chandler, Jr., Augusta; H. W. Muecke, Waycross; Robert A. Sears, Atlanta; J. W. Bennett, Augusta; W. G. Elliott, Cuthbert; W. U. Clary, Savannah; Fred E. Murphy, Jr., Thomasville; and Charles E. Irwin, Atlanta.

Eyecare of the Newborn—J. Jack Stokes, Atlanta, Chairman; Thomas C. McPherson, Atlanta; Joseph L. Girardeau, Atlanta; and C. A. N. Rankine, Atlanta.

Ministerial Liaison—Needham B. Bateman, Atlanta, Chairman; Avery M. Dimmock, Atlanta; Marion A. Hubert, Athens; Edward Y. Walker, Milledgeville; and F. G. Eldridge, Valdosta.

Physician-Lawyer Liaison—Hal M. Davison, Atlanta, Chairman; W. Bruce Schaefer, Toccoa; Charles S. Jones, Atlanta; W. L. Pomeroy, Waycross; A. B. Conger, Columbus; and Mr. John A. Dunaway, *ex-officio*.

It was moved that the special committee formerly termed "Calhoun Lectureship Committee" be renamed "Lectureship Committee", and this motion was so approved.

Lectureship Committee—David Henry Poer, Atlanta, Chairman; Murdock Euen, Atlanta; Glenville Giddings, Sr., Atlanta; and Floyd W. McRae, Atlanta.

Chairman Dillinger then appointed First Vice-President T. A. Peterson as chairman of all of the MAG standing committee chairmen and further assigned to Dr. Peterson the duty of stimulating MAG standing committee chairmen to activate their committee projects and plans and to aid in arranging a meeting of MAG

standing committee chairmen to accomplish such purposes.

These committees and appointments were approved.

Nursing Shortage Publicity—Mr. Krueger presented in behalf of J. Lee Walker, Chairman of the MAG Rural Health Committee, a request for the use of the Association's name in publicity for the Americus School of Practical Nurses to stimulate a greater enrollment in that institution. On motion duly made and seconded, it was voted that this item be referred to the Executive Committee of Council for action, with the request that information be sought from the local county society and that the Executive Committee, on the basis of information received, be empowered to act on this matter for Council.

MAG Sponsored Medical School Courses—Chris J. McLoughlin described a plan whereby the Medical Association of Georgia would sponsor from 10 to 12 one-hour lectures to be instituted in a short course and given at both of the medical schools in Georgia on the subject of the "Art of the Practice of Medicine." These courses would not deal with scientific medicine but rather emphasize subjects such as ethics, economics, medical organization, setting up a practice, insurance, hospital relations, etc. It was moved that the Medical Association of Georgia sponsor such short courses at both medical schools and that a committee of Council be appointed to initiate this project. This motion was approved. Chairman Dillinger appointed Chris J. McLoughlin, Chairman; J. Lee Walker, Clarkesville; and Rafe Banks, Gainesville, to serve in this capacity.

Catastrophic Hospitalization Insurance—David R. Thomas, Jr., Chairman of the MAG Insurance Board, presented a plan which the 1957 House of Delegates referred to Council with power to act on "Catastrophic Hospitalization Insurance" for the members of the Medical Association of Georgia. After general discussion of this insurance policy, it was moved that this policy be approved for MAG members and that a letter signed by the president be sent to all members of the Association on this subject informing them of the availability of this type of insurance, and further that introduction cards carrying the name of the Association be used by representatives of the Provident Life and Accident Insurance Company in calling upon the physicians of Georgia. It was noted in a general discussion following this motion, that the plan required no physical examination or medical questionnaires, but that 60 per cent of the eligible membership must participate in this plan before it could go into effect. Other aspects of the plan were fully discussed. The motion was then approved.

Medicare—A resolution from the Eighth District Medical Society concerning Medicare was presented as follows: "That the Eighth District Medical Society requests that the Council of the Medical Association of Georgia investigate the possibility of subletting the administration of Medicare to an appropriate agency experienced in insurance matters or to set up better facilities for handling the program more efficiently. It is further suggested by this society that a full fee schedule be furnished to each practicing physician in Georgia as soon as available." After general discussion it was moved that this resolution be accepted for information and taken under advisement. This motion was approved.

A resolution from the Medicare Review Board was

presented as follows: "That the Medicare Review Board recommend to the Council of the Medical Association of Georgia that the problems of administrative expenditures in operation of the Medicare program be determined by said Review Board insofar as they do not exceed the allowable cost per claim rate." After general discussion, it was moved that this resolution be adopted by Council. The motion was approved.

Dr. Jones presented the following: Renewal Supplemental Agreement 17 May 1957 Two Party Physicians Contract No. DA-49-007-MD-812 (covering the period of the contract which shall extend from 1 July 1957 through 28 February 1958) on the provisions of the Dependents' Medical Care Act, Public Law 569, 84th Congress. It was voted that the MAG present contract expiring June 30, 1957, be renewed per the above renewal supplemental agreement 17 May 1957.

The following resolution was approved.

RESOLVED that George R. Dillinger, Chairman of Council, and W. Bruce Schaefer, President of the Medical Association, be and they are hereby authorized to execute on behalf of the Medical Association of Georgia an amendment to Contract DA-49-007-MD-812 of 30 November 1956 as previously amended, said agreement being entitled "Renewal Supplemental Agreement to Two Party Physician Contract" and providing for extending the term of the contract to 28 February 1958 and making certain technical changes in the contract concerning the methods of reporting disbursements.

BE IT FURTHER RESOLVED that the Secretary of the Association in office at the time be, and he is hereby authorized, to sign on behalf of the Medical Association of Georgia the periodic form each time when due when required by the United States Government before advance payment entitled "Public Voucher for purposes and services other than personal" standard form No. 1034.

BE IT FURTHER RESOLVED that Council, already having delegated to the Executive Committee of Council the administration of the Medicare program as fiscal agent, authorize and empower said Executive Committee as delegate or delegates to take all of the necessary action and execute all of the required papers in connection with the administration of said contract as amended.

Charles S. Jones, Chairman of the Medicare Review Board, reported on the progress of MAG-Medicare for the first six months of the program. His report was received for information.

Headquarters Office—On motion duly made and seconded, it was voted (1) that an additional desk and chair be purchased for the amount of \$346.93; (2) that an office four-drawer file cabinet be purchased for an amount not to exceed \$50.00; and (3) that Mr. Krueger's expenses at the 1957 Annual Meeting of the AMA, \$312.74, be charged to "office travel."

Dr. McLoughlin discussed the need for air conditioning in the Headquarters Office, and it was moved that this problem be referred to the Finance Committee with the power to act, if feasible, by appropriating funds from the Reserve Fund. This motion was approved.

Mr. Krueger discussed the problem of an additional administrative secretary for the Headquarters Office,

and it was moved and seconded that this be accepted for information at this time. There was further discussion, and a substitute motion was made that the problem be investigated; that an attempt be made to locate such a secretary; and further that the Executive Committee be empowered to act on the matter in hiring such personnel, if feasible. The "information" motion was withdrawn and the second motion was approved.

Professional Conduct Committee Report—The MAG Professional Conduct Committee reporting on the "Barrett Case" reported the following opinion: "After reviewing the Barrett Case completely and having tried to be entirely impartial to anyone involved, we, the committee, are of the opinion that no action should be taken other than that already taken by the Crawford W. Long Medical Society. We believe that the case was handled at the local level in a satisfactory manner." After discussion, it was moved that this report be approved and that the secretary write the patient involved stating that the Association approves the report of its Professional Conduct Committee, etc. This motion was approved.

The Chairman called for unfinished business, and there being none, he called for new business.

Mr. Krueger presented a request from AMEF Committee Chairman Ben K. Looper for an appropriation of \$300.00 for future AMEF mailings. On motion duly made and seconded, it was voted that this item be referred to Executive Committee with the power to appropriate from the Reserve Fund, if they see fit.

Dr. McLoughlin introduced a recommendation concerning a shipboard cruise meeting planned for the Association's annual meeting or a post-convention cruise meeting. On motion duly made and seconded, it was voted that this recommendation be referred to the Annual Session Committee of Council.

Mr. Krueger reported on a physician-placement problem in Jeffersonville, and the report was referred to Charles H. Richardson, Sr., for action.

It was moved that the secretary be requested to write the family of Clarence B. Palmer expressing the sentiments of the Association officers and Council on the passing of Clarence B. Palmer, Covington. The motion further requested that the secretary write Charles R. Andrews expressing Council's wish for a speedy recovery from a recent motor vehicle accident. The motion was approved.

At this time, Hal M. Davison rose to invite the Council, in behalf of David Henry Poer, Chris J. McLoughlin and himself, to hold the September Council meeting in Atlanta. The Council voted to accept this invitation and to leave the date of this meeting to the discretion of the Executive Committee.

It was further noted that both Valdosta and Columbus issued invitations to the Council to meet in their cities in December. By general agreement, the Executive Committee of Council set Sunday, July 21, 1957, at 10 a.m., Headquarters Office, Atlanta, as the date and place of the next meeting.

Annual Session Committee Chairman Henry H. Tift announced that the dates of the 1958 Annual Session had been set: April 27-28-29-30, in Macon, Georgia.

On motion made and duly seconded the meeting was adjourned.

EXECUTIVE COMMITTEE

THE JUNE MEETING of the 1957-58 Executive Committee of the Council of the Medical Association of Georgia was called to order at 2:15 p.m., June 15, at the Dempsey Hotel, Macon, by Chairman George R. Dillinger.

Present, in addition to Dr. Dillinger were W. Bruce Schaefer, Toccoa, President; Hal M. Davison, Atlanta, Immediate Past President; Lee Howard, Sr., Savannah, President-Elect; Chris J. McLoughlin, Atlanta, Secretary-Treasurer; and J. G. McDaniel, Atlanta, Chairman, Finance Committee.

Also present was Mr. John F. Kiser of the MAG Headquarters Office.

Minutes of Council meetings on April 27 and May 1 and minutes of Executive Committee meeting on May 1 were reviewed by the Executive Committee.

Standing Committee Appointments—First item of business was the appointment of MAG standing committees by the Executive Committee. These appointments were as follows:

Cancer Committee—Hoke Wammock, Augusta, Chairman; J. E. Scarborough, Emory University; David Henry Poer, Atlanta; R. C. Pendergrass, Americus; Enoch Callaway, LaGrange; W. F. Jenkins, Columbus; John L. Barner, Athens; F. G. Eldridge, Valdosta; Lester Harbin, Rome; Everett L. Bishop, Atlanta; Thomas Harrold, Macon; Lee Howard, Sr., Savannah; Neal F. Yeomans, Waycross; Julian B. Neal, Thomasville; Major F. Fowler, Atlanta; Wadley R. Glenn, Atlanta; John T. Mauldin, Atlanta.

Constitution and By-Laws Committee—Thomas W. Goodwin, Augusta, Chairman; William P. Harbin, Rome; Eustace A. Allen, Atlanta.

Geriatrics Committee—Edgar Woody, Jr., Atlanta, Chairman; Peter L. Scardino, Savannah; Milton F. Bryant, Atlanta.

History and Vital Statistics Committee—J. Calvin Weaver, Atlanta, Chairman; Hoke Wammock, Augusta; R. H. McDonald, Newnan; Edgar Woody, Jr., Atlanta; Purcell Roberts, Atlanta.

Hospital Relations Committee—David Henry Poer, Atlanta, Chairman; Kirk Shepard, Thomasville; Robert B. Martin, Cuthbert; Herbert D. Tyler, Thomaston; Peter Hydrick, College Park; H. A. Goodwin, Summerville; James R. Paulk, Moultrie; Rafe Banks, Gainesville; A. W. Simpson, Jr., Washington.

Industrial Health Committee—Robert M. Harbin, Rome, Chairman; Joe M. Bosworth, Atlanta; T. A. Peterson, Savannah; Allen M. Collinsworth, Atlanta; J. H. Crowdis, Blakely.

Insurance and Economics Committee—David R. Thomas, Jr., Augusta, Chairman; 1st—John L. Elliott, Savannah; 2nd—Rudolph Bell, Thomasville; 3rd—Luther H. Wolff, Columbus; 4th—Thomas E. Floyd, Griffin; 5th—Charles S. Jones, Atlanta,

Co-Chairman; 6th—Herbert M. Olnick, Macon; 7th—E. S. Marks, Marietta; 8th—W. L. Pomeroy, Waycross; 9th—W. Perrin Nicolson, III, Gainesville; 10th—David R. Thomas, Jr., Augusta.

Legislation Committee—J. Frank Walker, Atlanta, Chairman; Eustace A. Allen, Atlanta, Vice-Chairman; M. F. Simmons, Decatur; Albert M. Deal, Statesboro; Virgil B. Williams, Griffin.

Crawford W. Long Memorial Committee—Lester Rumble, Jr., Atlanta, Chairman; Perry P. Volpitto, Augusta; A. B. Boyd, Athens.

Maternal and Infant Welfare Committee—Charles M. Mulherin, Augusta, Chairman, Hugh J. Bickerstaff, Columbus; Eugene L. Griffin, Atlanta; Thomas C. McPherson, Atlanta; Helen W. Bellhouse, Atlanta; James W. Bennett, Augusta; Peter Hydrick, College Park; George H. Alexander, Forsyth.

Medical Defense Committee—Charles S. Jones, Atlanta, Chairman; W. Bruce Schaefer, Toccoa; Lee Howard, Sr., Savannah; Chris J. McLoughlin, Atlanta; J. G. McDaniel, Atlanta.

Medical Education Committee—Thomas L. Ross, Jr., Macon, Chairman; Charles F. Stone, Atlanta; R. C. McGahee, Augusta; Harry B. O'Rear, Augusta, *ex-officio*; Arthur P. Richardson, Atlanta, *ex-officio*.

Mental Health Committee—Rives Chalmers, Atlanta, Chairman; J. R. Shannon Mays, Macon; Robert J. van de Wetering, Atlanta; Arthur M. Knight, Jr., Waycross; P. T. Scoggins, Commerce; Albert J. Kelley, Savannah; T. J. Vansant, Jr., Marietta; Corbett H. Thigpen, Augusta; Richard E. Felder, Atlanta; H. E. Valentine, Jr., Gainesville; T. G. Peacock, Milledgeville, consultant; Guy V. Rice, Atlanta, consultant.

Professional Conduct Committee—W. F. Reavis, Waycross, Chairman; C. F. Holton, Savannah; William P. Harbin, Jr., Rome; H. Dawson Allen, Jr., Milledgeville; Hal M. Davison, Atlanta.

Public Health Committee—Hugh J. Bickerstaff, Columbus, Chairman; John Venable, Atlanta; Hoke Wammock, Augusta; Thomas W. Goodwin, Augusta; Edgar Woody, Jr., Atlanta; J. Calvin Weaver, Atlanta; David Henry Poer, Atlanta; Robert M. Harbin, Rome; David R. Thomas, Jr., Augusta; J. Frank Walker, Atlanta; Lester Rumble, Jr., Atlanta; Charles M. Mulherin, Augusta; Charles S. Jones, Atlanta; Thomas L. Ross, Jr., Macon; Rives Chalmers, Atlanta; W. F. Reavis, Waycross; John P. Heard, Decatur; J. Lee Walker, Clarkesville; Ted F. Leigh, Emory University; Hartwell Joiner, Gainesville; Edgar M. Dunstan, Atlanta.

Public Service Committee—John P. Heard, Decatur, Chairman; E. P. Inglis, Marietta; Albert M. Boozer, Dalton; E. C. McMillan, Macon; Peter L. Scardino, Savannah; A. H. Letton, Atlanta; Peter Hydrick, College Park; Clarence C. Butler, Columbus; Thomas E. DuPree, Bainbridge.

Rural Health Committee—J. Lee Walker, Clarkesville, Chairman; 1st—Charles T. Brown, Guyton; 2nd—Henry A. Bridges, Bainbridge; 3rd—M. F. Arnold, Hawkinsville; 4th—T. A. Sappington, Thomaston; 5th—John P. Heard, Decatur; 6th—H. R. Cary, Milledgeville; 7th—H. C. Derrick, Lafayette; 8th—Sage Harper, Douglas; 9th—J. Lee Walker, Clarkesville; 10th—Hugh B. Cason, Warrenton.

Scientific Exhibit Awards—Ted F. Leigh, Emory University, Chairman (1960); Hoke Wammock, Augusta (1959); Charles H. Richardson, Jr., Macon (1958).

Veterans' Affairs Committee—Hartwell Joiner, Gainesville, Chairman (1958); Charles R. Andrews, Canton (1959); Lee Howard, Jr., Savannah (1960).

Woman's Auxiliary Committee—To be announced.

A motion to ask the Georgia Academy of General Practice to appoint a representative on the Maternal and Infant Welfare Committee to replace Fred H. Simonton, Chickamauga, who asked to be relieved of this position, was passed.

It was suggested that the Woman's Auxiliary Committee appointments be held in abeyance until the officers of the Woman's Auxiliary could be consulted.

Dr. Dillinger suggested that in the future the Executive Committee write the various committee chairmen in March for suggestions as to committee members and activity of the committee.

Headquarters Office Study—Dr. McLoughlin discussed the possibility of additional personnel and additional space for the Headquarters Office. He emphasized that no changes were needed in the present set-up of the office, but that possibly by the end of the year plans should be made for expansion of both personnel and available space.

Dues Raise Notification—Executive Committee members discussed the raise in dues authorized by the 1957 House of Delegates. It was voted to notify the county society secretaries through the *Officers Newsletter* and to publish in the *Journal* a notice of the dues increase. It was suggested that all announcements emphasize that this action was by a unanimous vote of the 1957 House of Delegates.

Headquarters Office Personnel—Mr. Kiser reported on the employment of a new managing editor for the *Journal*, Miss Helen Hendry, to replace Miss Frances Porcher who is leaving the Association on July 15th. Mr. Kiser pointed out that Miss Hendry would start on June 17th in order to work several weeks with Miss Porcher for on-the-job training.

Mr. Kiser discussed the need for additional personnel in the Medicare Department to replace Mrs. Buice, who is leaving due to pregnancy. Also, other changes for temporary employment to replace personnel leaving for several months was discussed.

It was voted to approve the action taken by the Headquarters Office in regard to replacement of personnel.

Finance Committee Report—J. G. McDaniel presented an audit by Ernst & Ernst of the books and records maintained in the office of the secretary-treasurer of the Association for the period of four months ended April 30, 1957. This audit was approved on motion duly made, seconded, and adopted.

Dr. McDaniel discussed the current budget of the Association and stated that for the first four months the Association had stayed within the budget except for certain items such as stationery, in which quantities to be needed later in the year had been purchased in advance.

Annual Session finance report was made by Dr. McDaniel as follows: at the March 9-10 Council meeting an Annual Session budget of approximately \$11,610.00 was submitted, and it was brought to the attention of

Council at that time that only \$10,000.00 had been budgeted for the 1957 Annual Session. The budget of \$11,610.00 was approved at the March 9-10 meeting, and to date, with approximately all bills for the Annual Session paid, the expense for the Annual Session is \$11,633.76 which is only a few dollars over the budgeted figure.

On motion duly made, seconded and adopted, this report was accepted.

There being no further business, this meeting was adjourned.

ANNOUNCEMENTS

Tennessee Valley Medical Assembly—Read House, Chattanooga, Tenn., September 30 and October 1, 1957. Speakers include the following: Paul Dudley White, Boston; Edith M. Lincoln, New York City; J. Arnold Barger, Rochester, Minn.; Philip J. Hodes, Philadelphia; Ernest B. Howard, Chicago; Harold A. Schofield, Oak Park, Ill.; I. S. Ravdin, Philadelphia; Joseph W. Kelso, Oklahoma City; Charles F. Geschickter, Washington; Irving S. Cooper, New York City; Meredith F. Campbell, Miami; Alexander Marble, Boston; and others. Banquet speaker will be Frank B. Berry, Washington. For reservations write to: Chattanooga Convention and Visitors Bureau, 819 Broad St., Chattanooga, Tenn. Registration fee: \$15.00, enclosed with reservation request, payable to Tenn. Valley Medical Assembly. AAGP approved, Category I.

1957 Convention, National Society for Crippled Children and Adults—Palmer House, Chicago, October 31 to November 2, 1957. Speeches, seminars, workshops, clinics, and demonstrations will spotlight the newest techniques and latest information in the care, treatment and training of the crippled. For further information write to The National Society for Crippled Children and Adults, 11 S. LaSalle St., Chicago 3, Ill.

World Congress of Gastroenterology—Sheraton Park Hotel, Washington, D. C., May 25-31, 1957. Subjects for discussion will be: Peptic Ulcer; Malabsorption and Sprue-like Syndromes; Nutrition and Its Effects on the Liver and Pancreas; Intestinal Infections and Infestations; Cancer of the Stomach (Epidemiologic and Experimental Aspects and Clinical Aspects); Original Contributions. Those desiring to participate in the scientific exhibits must contact Mr. Michael I. O'Conner, Mount Royal and Guilford Avenues, Baltimore 2, Maryland, U.S.A. Further details about the Congress, information about hotel reservations, fees, presentation of papers, etc., may be secured from H. M. Pollard, M.D., Secretary-General of the Congress, University Hospital, Ann Arbor, Michigan.

The First American Congress on Legal Medicine and Law-Science Problems—Hotel Morrison, Chicago, Illinois, July 8-13; 15-20, 1957. Featuring 165 specialists in sequences designed to cover chief phases of law-science problems important to trial lawyers and physicians concerned with personal injury and criminal litigation and legal problems of the medical profession. Conducted by the Law-Science Institute of the Schools of Law and Medicine, University of Texas, Austin, Texas. For further information write to the Law-Science Institute, c/o School of Law, University of Texas, Austin 12, Texas.

International Conference of Ultrasonics in Medicine—Statler Hotel, Los Angeles, California, September 6-7, 1957. Sponsored by the American Institute of Ultrasonics in Medicine. The meeting will cover the biological and physiological principles, as well as the clinical aspects of ultrasonics in medicine. There will also be a round table conference covering all these phases. Participating in the meeting will be representatives from Europe, South America, and Japan. For further details contact John H. Aldes, M.D., Secretary, 4833 Fountain Avenue, Los Angeles 29, California.

Awards in Obstetrics and Gynecology, International College of Surgeons—Two awards for the best manuscripts not exceeding 5,000 words submitted by December 1, 1957. First prize will be \$500 and the second \$300. Contestants must hold the degree of Doctor of Medicine from an accredited college of medicine, and be (1) interns, residents, or graduate students in obstetrics and gynecology, or (2) teachers of obstetrics and gynecology. Fellows of the College are not eligible. Details may be obtained by writing Harvey A. Gollin, M.D., Secretary of the Committee on Prizes, 55 East Washington Street, Chicago 2, Ill.

Caleb Fiske Prize Contest, Rhode Island Medical Society—Subject for this year's dissertation is "Hormonal Relationships in Breast and Prostatic Cancer—Their Practical Application." Essay must not exceed 10,000 words. Submission deadline is December 31, 1957. A cash prize of \$350 is offered. For complete information write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, R. I.

1958 Prize Scientific Paper Award, Southeastern Surgical Congress—For the best unpublished contribution on surgery or allied subjects, the author will be awarded \$100 and expenses to attend the next annual meeting of the Southeastern Surgical Congress in Baltimore, Maryland. The contest is open to residents in AMA approved residences in Georgia and other states. For further information write to The Southeastern Surgical Congress, 601 Hurt Building, Atlanta 3, Ga.

Urology Award, American Urological Association—An annual award of \$1000 (first prize of \$500, second prize \$300) for essays on the result of some clinical or laboratory research in urology. Competition limited to urologists who have been graduated not more than 10 years, and to hospital internes and residents doing research work in urology. All essays are due by December 1, 1957. For full information write Mr. William P. Didusch, Executive Secretary, 1120 North Charles Street, Baltimore, Md.

DEATHS

EMORY FRANKLIN CHAFFIN, Toccoa, died on May 21, 1957, at the age of 71. He suffered a heart attack a week before at his home in Toccoa.

Dr. Chaffin was born January 19, 1886, in Walton County. He attended State Normal School and graduated in 1914 from the Atlanta Medical College, now Emory University School of Medicine.

Dr. Chaffin began the practice of medicine at Martin

and later moved to Cornelia, moving his office to Toccoa in 1922.

He was a member and deacon of the Toccoa First Baptist Church, the Agoa Bible Class, and the Masonic Order. He belonged to the Stephens County Medical Society.

Surviving Dr. Chaffin are his wife, the former Miss Mabel Verner; a son, Mr. Verner Chaffin, Tuscaloosa, Ala. and three grandchildren.

Funeral services were held at the First Baptist Church in Toccoa; burial was in the Martin Cemetery. Members of the Stephens County Medical Society formed part of the honorary escort.

T. W. JACKSON, Manchester, died at his home on April 30, 1957, after a month's illness. He had retired from active practice 10 years ago.

Dr. Jackson is survived by his wife, the former Miss Lillie Mann, Manchester; a daughter, Mrs. W. B. Pournelle, Atlanta; two sons, Mr. Wofford L. Jackson and Calvin Jackson, M.D., both of Manchester; and seven grandchildren.

He was born in Habersham County and attended Dahlonga College, the University of Georgia, and graduated from the Atlanta School of Medicine, now Emory University School of Medicine. He came to Manchester in 1909, the year the city was incorporated. Dr. Jackson was a Life Member of Meriwether-Harris Medical Society.

Dr. Jackson was a deacon and charter member of the First Baptist Church. In 1911 he helped organize the Sunday School and was the first superintendent. He served as secretary-treasurer of the church for eight years. In 1953, the Manchester Junior Chamber of Commerce gave a dinner in Dr. Jackson's honor and presented him with a bronze plaque for his outstanding service to his community.

Funeral services were held on May 1 at the First Baptist Church with burial in City Cemetery.

J. E. LESTER, Marietta, Cobb County Health Commissioner for 30 years, died at his home in Marietta on May 11, 1957. He had been ill for quite some time.

Dr. Lester was born in Fulton County and studied medicine at the Atlanta College of Physicians and Surgeons, now part of Emory University. He did post-graduate work at New York Polyclinic Medical School and began his practice of medicine at Kennesaw in 1903. He remained there until 1926 when he became Commissioner of Health for Cobb county, a job he held continuously until his retirement on January 1.

Dr. Lester was a member of the Cobb County Medical Society and the Marietta Kiwanis Club, of which he was a past president. He was also a member of the Georgia and American Public Health Associations, the First Methodist Church of Marietta, Woodmen of the World, and the Masons.

Survivors include two daughters, Miss Verna Lester, Marietta, and Mrs. J. H. Hubbard, Emerson; a son, Mr. James Howard Lester, Marietta; seven grandchildren; and three great grandchildren.

Funeral services were held at the First Methodist Church with burial in Mountain View Park Cemetery.

MOSES SOLOMON LEVY, Smyrna, formerly of Augusta, died of a heart attack on May 23, 1957, at the age of 71. He had practiced medicine in Georgia for more than 50 years.

Dr. Levy was born in Savannah and was graduated from the Medical College of Georgia in 1906. He served on the Mexican Border in 1916 as commanding officer of the Old Georgia Hussars. He was on active duty with the U. S. Army for a short period of time during World War II and was retired as a lieutenant colonel.

Dr. Levy was active as a clinical professor at the Medical College of Georgia for many years and was an Active Member of the Richmond County Medical Society. In his later years he was a member of the Cobb County Medical Society. He was also an Active Member of the Association of Military Surgeons. Dr. Levy was one of the founders of the Augusta Chapter of the organized Reserves and was extremely active in this organization for 20 years.

Surviving Dr. Levy are his wife, Mrs. Mildred F. Levy; two sons, Lt. Col. J. W. Levy of the U. S. Army, and Tracy Levy, M. D., of the U. S. Public Health Service, Norfolk, Va.; one daughter, Mrs. Stanley Lane, Long Island, N. Y.; and seven grandchildren.

CHESTER K. LUKE, Alma, died on April 27, 1957, from injuries sustained in an automobile accident. Dr. Luke was 43 years of age at the time of his death.

A native of Nashville, he had practiced medicine in Alma for nine years. He graduated from Emory School of Medicine in the class of 1945 after having served as a captain in the U. S. Army during World War II, and he was a member of Phi Chi medical fraternity.

He is survived by his mother, Mrs. Leila Luke; two brothers, Mr. James L. Luke of Alma and Mr. Billy D. Luke of Augusta; and several aunts and uncles.

Funeral services were held at the Alma Methodist Church with burial in Nashville.

CLARENCE BRUCKNER PALMER, Covington, died on June 3, 1957, of a heart attack suffered earlier the same day. Dr. Palmer was 51 years old at the time of his death.

A native of Atlanta, Dr. Palmer was a graduate of Atlanta Boys' High School and Emory University, where he received his B. S. and M. D. degrees. His internship was served at Piedmont Hospital and Emory University Hospital, and his residency was served at New York Lying-In Hospital and the Albert Steiner Cancer Clinic, Atlanta. He was CCC Physician at Camp Rutledge from 1933 until 1937 when he began private practice in Covington.

During World War II, Dr. Palmer served with the U. S. Army Medical Corps in Europe; he was discharged from active duty with the rank of lieutenant colonel.

Dr. Palmer was for many years Athletic Physician for Covington schools; he was a past president of the Newton-Rockdale Medical Society; a vice-counselor of the Medical Association of Georgia; former chief-of-staff of the Newton County Hospital; Newton County Medical Examiner and City Physician. He was chief surgeon of the 81st Division, U. S. Army Reserves, a Kiwanian, Mason, and a member of the Episcopal Church of the Good Shepherd.

Funeral services were conducted at the Church of the Good Shepherd in Covington. Pallbearers were R. M. Sams, Goodwin Tuck, S. L. Waites, Jordan Callaway, R. M. Paty, F. C. Nesbit, James W. Purcell, Jr., and J. B. Mitchell, Jr. Burial was in National

Cemetery, Chattanooga, Tenn., with services conducted by the chaplains of the 81st Division.

Surviving Dr. Palmer are his wife, the former Miss Evelyn Kilmer; two daughters, Miss Clarie Palmer and Miss Vicky Palmer; and one son, Fred Palmer, who received his degree from the Emory University School of Medicine in June.

SOCIETIES

The THIRD DISTRICT MEDICAL SOCIETY met at Veterans State Park Memorial Building near Cordele in May, with the Flint and Sumter County Medical Societies acting as hosts. The scientific program featured the following: John W. Kemble, Augusta—"The Clinical Evaluation of Convulsive Disorders"; A. Calhoun Witham, Augusta—"Digitalis, a Two-Edged Sword"; George Smith, Augusta—"The Intervertebral Disc"; Thomas Findley, Augusta—"Diuresis and Anti-diuresis." Officers of the Third District Medical Society are as follows: O. T. Gower, Jr., Cordele, president; Dave Berman, Columbus, vicepresident; T. S. Gatewood, Americus, secretary; W. G. Elliott, Cuthbert, counselor; and Luther H. Wolff, Columbus, vice-counselor.

At the May meeting of the BALDWIN COUNTY MEDICAL SOCIETY, B. W. Forrester, Macon, spoke on coronary heart disease. The supper session was attended by some 30 physicians from the Milledgeville and Baldwin County area.

The regular meeting of the BIBB COUNTY MEDICAL SOCIETY was held on June 4, 1957, at the Pinebrook Inn, Macon. Claude Pennington presented a talk on "Sinus Disease." A golf tournament, sponsored by Pfizer Laboratories, was held for the doctors on May 16 at the Idle Hour Country Club—Oscar Spivey won the trophy for the low gross score. Approximately 50 people ate supper on the terrace after the tournament.

At the May meeting of the GEORGIA MEDICAL SOCIETY in Savannah, Edward F. Parker, Charleston, spoke on "Experience with Cardio-Pulmonary Bypass." Dr. Parker is associate professor of surgery at the Medical College of South Carolina and consultant in thoracic surgery for the Veterans Administration in the Southeast.

The doctors of the UPSON COUNTY MEDICAL SOCIETY entertained their wives with a dinner party on Saturday, May 25, at the Thomaston Country Club. This celebration has been held for the past several years to honor the women, who are members of the auxiliary to the society, for the awards they have been bringing home from the annual session each year. This year they brought home the silver cup, among other honors. T. A. Sappington was in charge of the affair, with Douglas Head, Pruitt Woodall, and John Blackburn in charge of the cooking.

Members of the WARE COUNTY MEDICAL SOCIETY met in May to hear John Caldwell, professor of psychiatry at the Medical College of Georgia, Augusta, discuss the use of the newer tranquilizers for the treatment of patients in acute mental states resulting from alcohol.

PERSONALS

Officers have been elected by the members of the Medical College of Georgia Alumni to serve for the coming year. Walter E. Brown, Savannah, was named president; vice-presidents are George A. Holloway, Atlanta, Neal F. Yeomans, Waycross, and W. Steve Worthy, Carrollton; Joseph L. Mulherin was named secretary-treasurer for three years; and the following physicians were named to the Board of Managers for one year each: John A. Simpson, Athens, Herman L. Dismukes, Ocilla; for two years: Edgar D. Shanks, Atlanta, and W. Joseph Williams, Augusta; and for three years: W. Frank McKemie, Albany, and H. Brantley, Donalsonville.

First District

T. A. AMBURGEY, Savannah, medical director of the newly dedicated Clair Henderson Memorial Rehabilitation Center, addressed a recent meeting of the Pilot Club of Savannah. D. Amburgey outlined the early formation of the center and described its over-all program. The speaker was introduced by WILLIAM WEICHSELBAUM, Savannah.

CHARLES G. GREEN, Waynesboro, spoke to the Waynesboro Exchange Club, at a recent meeting, on the use of tranquilizers.

JOHN C. HOWARD, Savannah, has announced the opening of an office at 202 East Liberty Street, Savannah, for the practice of medicine, specializing in diseases of the eye, ear, nose and throat. Dr. Howard is the son of Dr. and Mrs. LEE HOWARD, SR., Savannah, and the brother of LEE HOWARD, JR., Savannah. He is a graduate of Duke University and Duke Medical School, class of 1943. He served his internship at Reading (Pa.) General Hospital and his residency at the Central of Georgia Hospital, Lawson General Hospital, and Emory University Hospital. For the past four years he has been in private practice in Athens. There he was chief of staff of St. Mary's Hospital and chief of the eye, ear, nose, and throat section at St. Mary's and General Hospital. He is a diplomate of the American Board of Otolaryngology and a member of the American Academy and the Georgia Society of Ophthalmology and Otolaryngology. Dr. and Mrs. Howard and their four children will reside at 21 East 53rd Street.

G. H. LANG, Savannah, has announced his retirement from active practice, effective May 6, 1957. A native of Savannah, Dr. Lang has practiced there since 1915, specializing in diseases of the eye, ear, nose, and throat. Dr. Lang is a senior fellow of the Southeastern Surgical Congress, a past president of the Georgia Medical Society, and a fellow of the American College of Surgeons.

DAVID ROBINSON, Savannah, announces the association with him in the practice of radiology of Jack Marvin Levene, formerly of Binghamton, N. Y. Dr. Levene is a graduate of Cornell University; he received the M. S. degree from the University of Rochester School of Medicine and the M. D. degree

from Syracuse University College of Medicine. He interned at Brooklyn Jewish Hospital and was later assistant resident in radiology there. Dr. Levene served in the U. S. Army and was later associate resident and chief resident in radiology at the University of Rochester School of Medicine. He is a diplomate of the American Board of Radiology.

EDWIN C. SHEPHERD, Savannah, has been elected to fellowship in the American Academy of Pediatrics it has been announced.

Second District

No news received.

Third District

A. C. HOBBS, JR., Columbus, recently returned from Europe where he attended the French Congress of Ophthalmology in Paris.

W. G. ELLIOTT, Cuthbert, has been made a fellow of the American College of Chest Physicians. The honor was conferred at the annual meeting at the Hotel Commodore, New York City, June 1.

The relationship between physician and emotional ills was discussed by A. B. CONGER, HARRY H. BRILL, JR., CLARENCE BUTLER, and CHARLES R. SMITH, all of Columbus, at a recent meeting held at the Muscogee Health Center. LEONARD T. MAHOLICK, Columbus, was the panel moderator, and the seminar was sponsored by the Community Guidance Council and the Pilot Club.

Fourth District

ED T. ARNOLD, JR., Hogansville, suffered a heart attack in May and was hospitalized for a short time. Our best wishes for a speedy and complete recovery.

The *Journal* regrets to announce the death of Mrs. Sara Elizabeth Andrews Brown, wife of GEORGE W. BROWN, Griffin, on May 4, 1957. Other survivors include their three sons, Fred, George Jr., and Tommy; and one daughter, Carol Ann.

Fifth District

The North Side (Atlanta) Branch of the YMCA conducted a three part series of sex education lectures for fathers and sons entitled "From Boyhood to Manhood." Each session was attended by over 200 fathers and sons. Principal speakers for the series were CHARLES S. JONES, W. H. GRIMES, JR., and HERBERT S. ALDEN, all of Atlanta.

WINSTON E. BURDINE, Atlanta, was the principal speaker at a recent meeting of the Rome Exchange Club.

RIVES CHALMERS, Atlanta, in addressing the members of the Decatur Rotary Club recently spoke on "Mental Health," stressing the concern of some members of the medical profession over the widespread use of the new tranquilizer drugs by people who don't need them.

MURDOCK EQUEN, Atlanta, recently read a paper on the "Magnetic Removal of Foreign Bodies from the Air and Food Passages" before the International Congress on Otolaryngology in Washington, D. C.

J. F. HACKNEY, Atlanta, has been named president-elect of the Georgia Public Health Association. The election was held at the 28th Annual Convention of the association in Augusta in May.

The Atlanta Medical Women's Club has elected the following officers: DOROTHY JAEGER-LEE, president; LILA BONNER MILLER, vice-president; MARGUERITE L. CANDLER, secretary, and DOROTHY BRINSFIELD, treasurer.

A. HAMBLIN LETTON, Atlanta, attended the meeting of the American Goiter Association in New York in May.

JOHN R. LEWIS, JR., Atlanta, has been elected first vice-president of the Atlanta Writers Club. Dr. Lewis' poetry, which he writes for relaxation, has already received several awards in the Writers Club.

BERNARD S. LIPMAN, Atlanta, attended the meeting of the American College of Physicians held in April. He was inducted as a fellow at the Convocation. Dr. and Mrs. Lipman took the postconvention tour to the West Indies, making the following stops: San Juan, Puerto Rico; St. Thomas, V. I.; Ciudad Trujillo, Dominican Republic; Port au Prince, Haiti; Montego Bay, Jamaica.

Two sons of HAROLD P. McDONALD, Atlanta, and grandsons of PAUL McDONALD, Bolton, became doctors of medicine this June. Harold P. McDonald, Jr., graduated from the Medical College of Georgia in Augusta on June 8, and Lawrence Patton McDonald received his degree from Emory University School of Medicine the day before, June 7, Dr. Harold McDonald, Sr.'s birthday.

F. LEVERING NEELY, Atlanta, is the new president of the Georgia Chapter of the American College of Chest Physicians; JAMES L. ALEXANDER, Savannah, is vice-president; and M. BEDFORD DAVIS, JR., Atlanta, is the secretary-treasurer.

Sixth District

Several members of the Peach Belt Medical Association recently conducted a panel discussion in Warner Robins on infectious and communicable diseases. Members of the panel were J. JAY GOLDSTEIN, Warner Robins; DAN CALLAHAN, Warner Robins; H. E. WEEMS, Perry; and FRANK VINSON, Ft. Valley. The forum was sponsored by the Inter-Organizational Council.

A bronze plaque, dedicated to the memory of the late ROBERT L. WHIPPLE, SR., was unveiled recently in Cochran.

Seventh District

Dr. and Mrs. HARRY B. BRADFORD, Cartersville, recently attended a dinner at the Atlanta Athletic Club in celebration of the 40th anniversary celebration of the graduation of Dr. Bradford's class from Medical school.

RAYMOND F. CORPE, Rome, participated in a panel discussion at the annual meeting of the American College of Chest Physicians in New York City. The panel topic was "The General Treatment of Tuberculosis."

WALTER G. CRAWLEY, Marietta, was named president-elect of the Georgia Pediatric Society at the annual session of the MAG in Savannah.

Dr. and Mrs. J. E. GRIFFITH, Atlanta, celebrated their silver anniversary on April 27, 1957, at the Druid Hills Golf club with a cocktail party, buffet dinner, and dance.

Three Calhoun doctors discussed questions on cancer and heart diseases at a regular meeting of the local Rotary Club. Leading the discussion were W. D. HALL, CHARLES K. RICHARDS, and R. D. WALTER.

VIRGINIA H. MALEY, Cartersville, was the principal speaker at a recent meeting of the Cartersville Service League. She also attended the Georgia Public Health convention in Augusta in May.

Eighth District

E. ADAMS DANEMAN, Waycross, read a paper on "Pastoral Counseling" at the American Psychiatric Association in Chicago in May 1957; he was also the guest speaker at a meeting of the Pierce County Mental Health Association on June 3.

J. M. JACKSON, Folkston, has recently acquired full interest in the McCoy-Jackson Hospital. Dr. Jackson came to Folkston in 1947 from Waycross, where he had been connected with the Atlantic Coast Line Hospital, to practice with W. R. MCCOY. Some time later he acquired half interest in the hospital, and he has now become sole owner, effective July 1, 1957.

J. B. OLIPHANT, Adel, has recently been declared Cook County's "Citizen of the Year." Dr. Oliphant was awarded this honor at the Lion Club's annual Ladies Night banquet, where he was presented with an inscribed plaque. Dr. Oliphant came to Cook County in 1943. He is a member of the Baptist Church and has served on the Board of Deacons for both the Sparks and Adel Churches. He has also served on the City Council of the two towns and is Past Commander of the American Legion, a member of the Kiwanis and Elks Clubs, a Mason, Shriner, and a member of the Eastern Star.

C. R. YOUMANS, Hazlehurst, has been elected president of the Kiwanis Club for the second time in seven years.

Ninth District

GUY O. EVERHART, Loganville, has announced that WILLIAM L. CATON is now associated with him in practice at the Loganville Clinic. Dr. Caton graduated from Harvard Medical School and later served there as an associate professor of gynecology and obstetrics. He was more recently professor and head of the department of obstetrics and gynecology at Emory University School of Medicine.

RAYMOND D. EVANS, Clayton, has been appointed to the State Medical Education Board and elected to serve as chairman. Dr. Evans' duties will entail the screening of candidates applying for assistance under the present law which provides funds for medical education to students who, in return, agree to practice medicine in rural Georgia communities. Dr. Evans himself was a recipient of such a scholarship.

WILLIAM H. GOOD and ARTHUR G. SINGER, both of Toccoa, recently dedicated their new Toccoa Clinic building. Dr. Good outlined the history of the clinic and Dr. Singer described the type of construction and layout of the building. The clinic opens with a staff of five doctors, several secretaries, two trained nurses, and a laboratory technician.

C. J. ROPER, Jasper, was speaker at a recent Canton Kiwanis Club meeting honoring local doctors. Dr. Roper spoke on the advances of modern medicine and its present day use. Other doctors present were T. J. VANSANT, CHARLES R. ANDREWS, GRADY N. COKER, BEN K. LOPPER, JOHN A. CAUBLE, ROBERT T. JONES, III, A. M. HENDRIX, and W. H. NICHOLS, JR., all of Canton.

The marriage of Mr. William Bruce Schaefer, Jr., son of Dr. and Mrs. WILLIAM BRUCE SCHAEFER, of Toccoa, to Miss Nancy Isabelle Smith, Toccoa, has been announced. The wedding took place on June 28.

C. B. WATKINS, Ellijay, announces the removal of his office to 33 Spring St., adjoining the office of C. B. TEAL, JR. Dr. Watkins and Dr. Teal will in the future be associates in the practice of medicine.

Tenth District

LESTER L. BOWLES, Augusta, chairman of the Department of Microscopic Anatomy at the Medical College of Georgia, recently received an alumni citation from Franklin College, Franklin, Indiana, during the Alumni Day celebrations. The awards are made annually to Franklin alumni who have, in the opinion of the Alumni Council, achieved prominence in their chosen field of work. Dr. Bowles is a native of Indiana and was graduated from Franklin in 1943. He received his M. D. degree at Indiana University in 1938. He has done research in histology, embryology, and neuroanatomy. In 1956, Dr. Bowles received the Cadaver Award from students of the Medical College of Georgia for excellence in teaching.



Left to right: Hugh Smisson, president of the student body at the Medical College of Georgia, 1956-57; William J. Darby, professor and head of the Department of Biochemistry, Vanderbilt University School of Medicine; Mrs. V. P. Sydenstricker, and Dr. Sydenstricker, retiring professor and head of the Department of Medicine and dean of Postgraduate Medical Education, Medical College of Georgia.

GOODLOE Y. ERWIN, Athens, president-elect of the Georgia Heart Association, was one of six delegates from the G. H. A. attending the 10-state Southern Regional Conference of the American Heart Association held in St. Petersburg, Florida.

THOMAS FINDLEY, Augusta, was a member of the Executive Committee Section on Experimental Medicine and Therapeutics at the annual meeting of the American Association in New York, June 1957.

ROBERT B. GREENBLATT, Augusta, recently attended the meeting of the Postgraduate Committee of the Endocrine Society in New York City, where he presented a paper on "Gonadal Dysgenesis." While in New York, Dr. Greenblatt acted as chairman of the Membership Committee Meeting of the American Geriatrics Society. On June 2, he was chairman of a conference of the Board of Directors for the American Society for the Study of Sterility. Later in the month he presented an exhibit, "Infertility: Diagnosis and Treatment," at the meeting of the A. M. A. in New York.

Mrs. Edgar Maxwell, Sr., mother of E. J. MAXWELL, Thomson, was recently chosen Georgia's "Mother of the Year."

HARRY B. O'REAR, Augusta, presented a film entitled, "Teacher Observation of School Children," at a recent meeting of the Parents' Association of the Episcopal Day School.

John A. Owen, Augusta, is the recipient of a grant from the Eli Lilly Research Laboratories, Indianapolis, Indiana. This grant, of \$3,529.41, will assist in the studies of the "Interaction of the Sulfonylurea Compounds and Growth Hormones" in an effort to see how these compounds produce an artificial diabetic condition. Dr. Owen has also been elected to membership in the Endocrine Society.

The annual award of the Southeastern Section of the American Urological Association was won by J. ROBERT RINKER, professor of surgery and chief of urology, Medical College of Georgia, Augusta. The award is given each year for excellence in presentation of the most instructive and outstanding urological problem case.

May 24, 1957, was proclaimed by EDGAR R. PUND, president of the Medical College of Georgia, to be "V. P. SYDENSTRICKER DAY" at the Medical College of Georgia. Dr. Sydenstricker is retiring as professor of medicine, a position he has held since 1922. On his day, there were speeches, a lecture and luncheon where Dr. Sydenstricker was presented with a silver bowl filled with U. S. Savings Bonds (see cut). It was also announced that a lectureship has been established in his honor to bring a prominent speaker to the campus once during each year.

WILLIAM A. WILKES, Augusta, has been elected to fellowship in the American Academy of Pediatrics.

A. CALHOUN WITHAM, Augusta, attended the Conference of Cardiovascular Undergraduate Training Grant Program Directors in Sun Valley, Idaho, in June.

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Photo by Ted F. Leigh—Medical Grand Rounds

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C. W. Long Museum Dedication

THE CRAWFORD W. LONG Memorial Museum in Jefferson, Georgia, will be dedicated Sunday, September 15, 1957, at 3:00 p.m. Many prominent guests will participate in the program, the speaker to be the Honorable Herman Talmadge, United States Senator from Georgia, and the dedication to be made by Governor Marvin Griffin. It is anticipated that the President of the Medical Association of Georgia, the President of the American Society of Anesthesiology, along with officials of the state of Georgia and officials from the pharmaceutical societies, will be present for the occasion.

The officers and members of the Council of the Medical Association of Georgia will attend this memorable ceremony, and it is most important that a large number of Georgia physicians participate in this event. To that end, every Georgia doctor of medicine is cordially invited to take part in this dedication. Festivities will begin about 1:00, and the actual dedication ceremony will start promptly at 3:00. You are urged to make plans to attend now.

MAG Distinguished Service Award

On recommendation of the 1957 House of Delegates, the Council has appointed a committee to initiate an annual Association award to be presented at the MAG Annual Session to a physician who has rendered extraordinary service to his profession. The committee will convene to recommend "ground rules" for such an award to be given in recognition of the physician's outstanding contribution to the Association in any one year. Probably the basis for such recognition would lie in the non-scientific field of service since other awards are now established for scientific contribution.

MAG Medical School Course

It has long been recognized that the medical school curriculum contains little instruction on the "facts of life" in the medical profession. To that end, the Council has appointed a committee to design and recommend such a course for inclusion in the curriculum of both the medical schools in Georgia. Progress has been made in liaison with both medical schools and present plans call for such a course to be instituted during the 1958 school year for senior medical students. The course covers a wide range of problems besetting the physician in

his early years of practice. Emphasis of the course is in non-scientific fields dealing with the art of the practice of medicine.

Physician-Lawyer Relations Code

Aware of the increasing complexities in the practice of medicine, the Council has appointed a committee to initiate a code for professional relationships between physicians and lawyers. While this objective has been achieved in other states and by some of the larger county medical societies in Georgia, MAG proposes to establish a state-wide code as a guide and a model for component county medical societies. A physician from each district of the state has been appointed to the MAG committee along with representatives of the Georgia Bar Association and the MAG Attorney, Mr. John Dunaway.

'58 Annual Session

MAG 1958 Annual Session will be held April 27-30, 1958, Macon, Georgia. Tentative outline of the program is as follows:

SUNDAY, APRIL 27—2:00 to 5:00, *Section Meetings*; 5:00 to 6:30, *House of Delegates*; 7:00, *Specialty Society Dinners*.

MONDAY, APRIL 28—9:00 a.m. to 12:00 noon, *General Session "G. P. Day,"* 12:00 to 1:00, *General Session Business Meeting*; 1:00 to 2:00, *Specialty Society Luncheons*; 2:30 to 5:00, *Section Meetings*; 5:00 to 8:00, *Alumni Dinners*; 8:00, *General Session "G. P. Day" Reconvened*.

TUESDAY, APRIL 29—9:00 a.m. to 12:00 noon, *Section Meetings*; 12:00 to 1:00, *General Session Lectureship*; 1:00 to 2:00, *Specialty Society Luncheons*; 2:30 to 5:00, *Section Meetings*; 6:30, *Social Hour*; 8:00, *President's Dinner*.

WEDNESDAY, APRIL 30—9:00 a.m. to 11:30 a.m. *House of Delegates (2nd Session)*; 11:30, *General Session Business Meeting (2nd Session)*.

Please note that tentatively the 2nd Session of the House of Delegates has been switched from the traditional Tuesday afternoon spot to a Wednesday morning session. In its place, Tuesday afternoon, section meetings will convene. This change was proposed to provide more time for section meetings, to prevent overlapping of meetings, and to spread these scientific meetings out more evenly throughout the program.

Specialty Society program chairmen handling the

1958 Annual Session

April 27-30, 1958—Macon, Georgia



First Call for Scientific Papers

All titles must be submitted to the respective program chairmen listed below before November 1, 1957.

ANESTHESIOLOGY

Elmer Lee Fry, M.D.
781 Spring Street, Macon

DIABETES

Harold A. Ferris, M.D.
340 Boulevard, N.E., Atlanta

GENERAL PRACTICE

Frank M. Houser, M.D.
781 Spring Street, Macon

INDUSTRIAL SURGERY

Joseph L. Kurtz, M.D.
663 W. Peachtree Street, N.E., Atlanta

MEDICINE

Haywood N. Hill, M.D.
46 Fifth Street, N.E., Atlanta

OBSTETRICS AND GYNECOLOGY

Jule C. Neal, M.D.
203 Professional Building, Macon

EENT

F. P. Calhoun, M.D.
478 Peachtree Street, N.E., Atlanta

ORTHOPEDICS

Walter Barnes, Jr., M.D.
724 Hemlock Street, Macon

PATHOLOGY

Leonard H. Campbell, M.D.
Macon Hospital, Macon

PEDIATRICS

Edwin R. Watson, M.D.
745 Pine Street, Macon

PSYCHIATRY

J. R. S. Mays, M.D.
700 Spring Street, Macon

RADIOLOGY

W. H. Somers, M.D.
Macon Hospital, Macon

SURGERY

C. H. Richardson, Jr., M.D.
700 Spring Street, Macon

THORACIC MEDICINE

Samuel E. Paton, M.D.
797 Poplar Street, Macon

UROLOGY

Charles Rieser, M.D.
819 Cypress Street, N.E., Atlanta

section meetings have met and chosen their time, date, and place, and these chairmen are now in the process of arranging the MAG section meetings and Specialty Society luncheons and dinners.

County Medical Society Responsibility

The majority of component county medical societies, recognized as the medical authorities in their county, have been and will continue to serve their respective communities—but the public in these communities has little or no idea of the width and breadth of the society's activity in its behalf. The

problem lies in communicating to the community information about the service rendered by the society. If the society is to better serve, it behooves the society to tell its story of service. Civic clubs would welcome this type of information; newspapers are always ready to publicize civic service; and there are many ways to let the public know about the activity of the society. Let each county medical society expend its effort in telling its "story of community service" to the townspeople so that an increasing amount of service can be rendered and so that a renewed respect of the society may be engendered.

RECONSTRUCTION OF THE FACE FOLLOWING TREATMENT OF CANCER

On the face it is possible to reconstruct immediately certain defects that result from the surgical treatment of cancer without impairing the cure rate. Some typical examples of various types of plastic reconstruction are reported.

FRANK F. KANTHAK, M.D., D.D.S., *Atlanta, Georgia*

THE SURGICAL TREATMENT of cancer of the face often entails considerable destruction of the surface or of one or more features, resulting in both functional and cosmetic distortions of the normal physiognomy. While both cautery destruction and x-ray therapy have a place in the treatment of cancer of this region, continued application of these destructive agents, particularly on an already somewhat devitalized skin, may lead to secondary changes which will result in additional neoplastic lesions. For these reasons, and others, primary resort to surgical treatment is the treatment of choice in many of the cancers of the face.

Occasionally the results of the surgical treatment of cancer of the face are poor because of the reluctance on the part of the surgeon to excise sufficiently the area of tumor involvement. This is a natural reluctance because of the deformity and disfigurement that may be produced by the adequate treatment of the disease. However, it should be remembered that the first objective is to produce a cure of the disease and the second, to repair the part destroyed. The primary objective should be attained in most instances where surgically feasible.

Not infrequently patients can be spared discomfort and functional embarrassment by immediately reconstructing a part which has been destroyed by the treatment of cancer. An argument is frequently brought up that one should wait a suitable interval before repairing these defects and, in general, this is agreed with because immediate repair utilizes the most available tissues for reconstruction. If recurrence of the lesion should follow, then distant tissue must be used which will make further reconstruction more difficult. However, it must be realized that in other parts of the body immediate repair is done with fairly satisfactory results. For example, in tumors of the breast immediate reconstruction is followed by a cure rate that probably would not be improved by allowing the area to remain open. In the face, it is also possible to reconstruct immediately certain defects that result from the surgical treatment of cancer without impairing the cure rate. A recurrent cancer of the face is usually readily accessible and can be detected without too much difficulty if one is alert to its possible recurrence.

This paper, then, reports some typical examples of various types of cancers of the face and the reconstruction, either immediate or delayed, of the facial structures. It is important to emphasize that

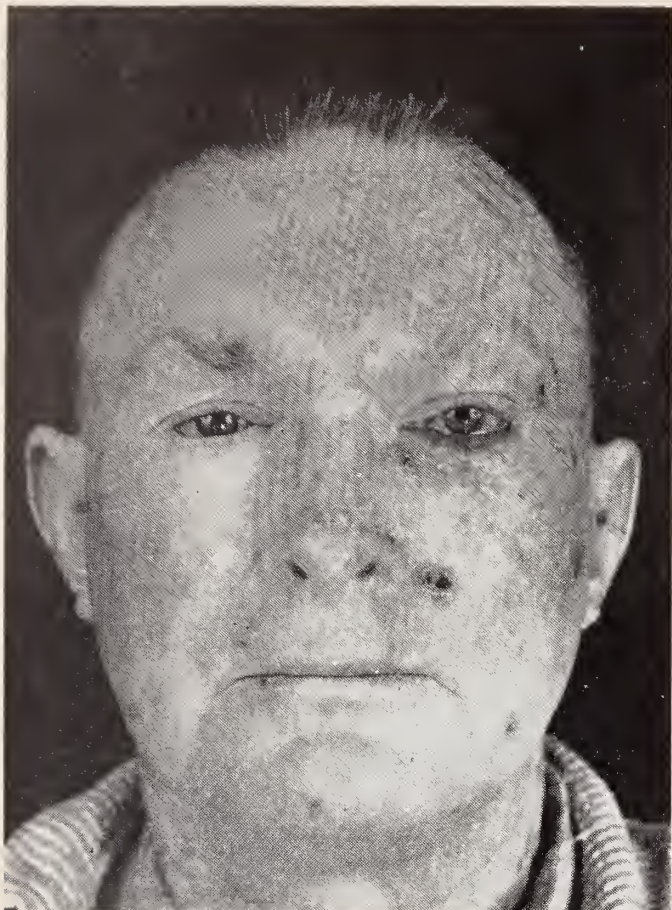


FIGURE 1: Case I. Chronic degenerative changes in the skin associated with basaloid squamous cell carcinoma. Patient has had x-ray irradiation and numerous fulgurations with recurrences and the development of new lesions. Note the ectropion of the lower left eyelid.



FIGURE 2: Case I. Complete excision of involved and scarred tissue down to normal subcutaneous base.



FIGURE 3: Case I. Split thickness skin graft contoured and sutured in position, prior to placing the dressing.

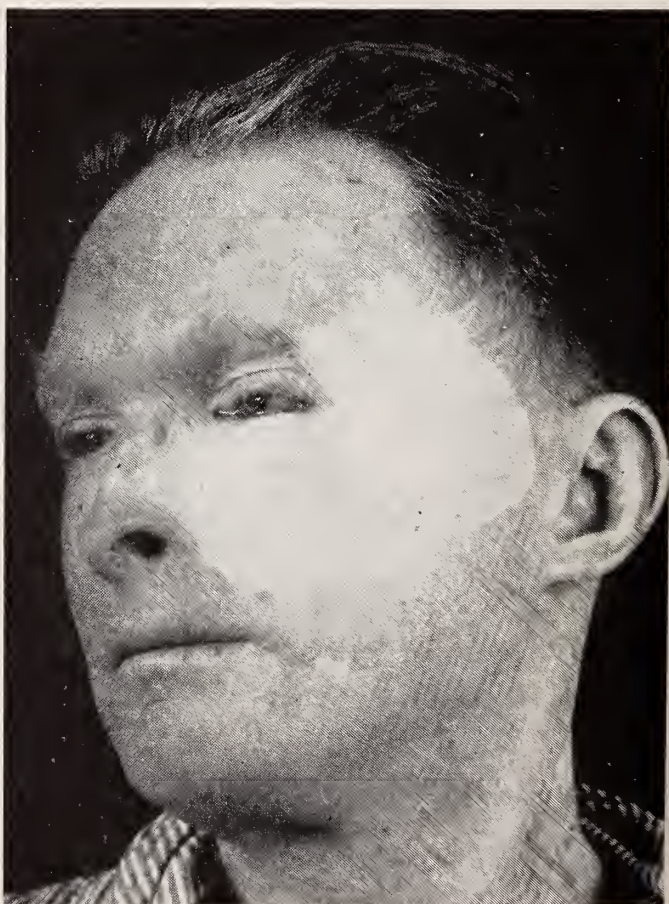


FIGURE 4: Case I. Grafted area healed with satisfactory functional and cosmetic result. Ectropion corrected.

RECONSTRUCTION OF FACE / Kanthak

ultimate reconstruction of the face is essential to most of these individuals so that they can resume ordinary social intercourse without being made to feel conspicuous because of a bandage or because of some device which is attached to the skin to simulate the appearance of a lost feature.

CASE I

Case I is a 52-year-old farmer afflicted with multiple squamous and basal cell carcinomas of the face. These had been treated by electro-desiccation and small amounts of radiation with the disappearance of many of the lesions but with the appearance of many others. The skin was markedly atrophic with multiple keratoses and, in certain areas, frank neoplastic change (Figure 1). When skin of this type becomes so extensively involved with both disease and the effects of treatment, there is only one satisfactory way to treat it and that is to permanently remove the involved skin and to substitute unblemished skin. This is done by completely excising the area of involvement (Figure 2), perhaps in stages if necessary, and replacing it with a suitable skin graft from some other part of the body, making the graft conform exactly to the defect (Figure 3). Thus, an entirely new surface of the face is created. It is important to note the texture of the skin graft is different from that of the remainder of the face and that the other is less pink (Figure 4). However, the meticulous individual can disguise these discrepancies somewhat by means of cosmetics.

It is frequently asked if skin grafts placed on an exposed portion of the body in the susceptible patient, such as this, will not show degenerative changes also. However, in cancer patients who have been observed for as long as 10 years with skin grafts on the face, there have been no changes within the skin grafts themselves, although the remainder of the facial skin has continued to deteriorate.

This, then, in my opinion, is the treatment of choice: The sharp dissection or excision of the involved area and immediate replacement with a skin graft which will supply the lost surface of the face. In general, I am not in favor of using either the electro-cautery or the hot cautery for accessible lesions of the face because the amount of destruction produced cannot be controlled and also because a burn is superimposed on the destruction that could be as simply and effectively accomplished by means of a scalpel.

I view with dismay areas of tissue which have been burned and charred with the cautery or areas of bone, say in the mandible, which have been thoroughly cooked with the cautery and allowed to re-

main to exfoliate spontaneously. At the conclusion of the operation, these areas could be removed by a clean surgical method, fixing the teeth, if any, in position on the opposite side of the mouth to hold the position of the jaws, thus sparing the patient much suffering and suppuration. The wounds will heal more quickly, and I feel that nothing is gained by allowing these dead tissues to remain in situ when they can be readily removed as a concluding part of the procedure. In my own experience, I very seldom use the hot cautery or electro-desiccation, finding it more effective to excise the lesion widely and to rely on sharp dissection or excision for the eradication of the tumor. Occasionally tumors will be removed in a block of tissue, marked to orient them, and sent to the laboratory for sections from the periphery so that any questionable margin can be re-excised to attain further insurance of adequate removal.

CASE II

This 46-year-old colored man had an extensive ameloblastoma of the mandible which had been growing slowly but steadily for many years (Figure 5). No previous treatment had been given this tumor. Clinical and radiographic examination indicated that the entire body of the mandible from one angle to the other was involved by an expanding multilocular solid and cystic tumor. The mandible was excised (Figure 6), and the jaw and tongue positions were controlled by fixation of the right and left posterior fragments by a single Steinmann pin which was contoured at the operating table (Figure 7). Healing proceeded without event, and later iliac bone grafts were used to produce bony restoration of the mandible. The pin was still in situ five years later, giving no difficulty and helping to preserve the contour of the jaw (Figure 8). This, in my opinion, is the simplest and most effective method of dealing with portions of the mandible which cannot be controlled by conventional interdental fixation and traction. Where teeth are absent or where the tooth-bearing portions of the jaw are excised, a contoured heavy Steinmann pin deeply countersunk into the mandibular canals will provide good fixation of the parts.

CASE III

Case III is a 28-year-old man with a lesion of the right infraorbital area which had been treated by x-ray therapy. The lesion recurred, and a biopsy was taken which showed a squamous cell carcinoma which was then inadequately excised. At the time of admission to the hospital he had a small lesion attached to the anterior surface of the maxilla with a small amount of radiation change and also a surgical scar in the area (Figure 9). Treatment consisted of wide surgical removal, including removal of the

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anterior wall of the maxillary sinus (Figure 10). An adjacent flap was elevated from the face, completely detached from the underlying tissue, turned into position, and sutured in place with interrupted stitches of 3-0 plain catgut and 5-0 silk. A small defect remaining in front of the ear was then closed by a full thickness skin graft taken from behind the right ear, thereby closing the whole created defect (Figures 11 and 12). One week later a small tag of



FIGURE 5: Case II. Large ameloblastoma involving the entire body of the mandible.



FIGURE 6: Case II. Specimen of ameloblastoma excised requiring removal of mandibular bodies to the ramus on each side.

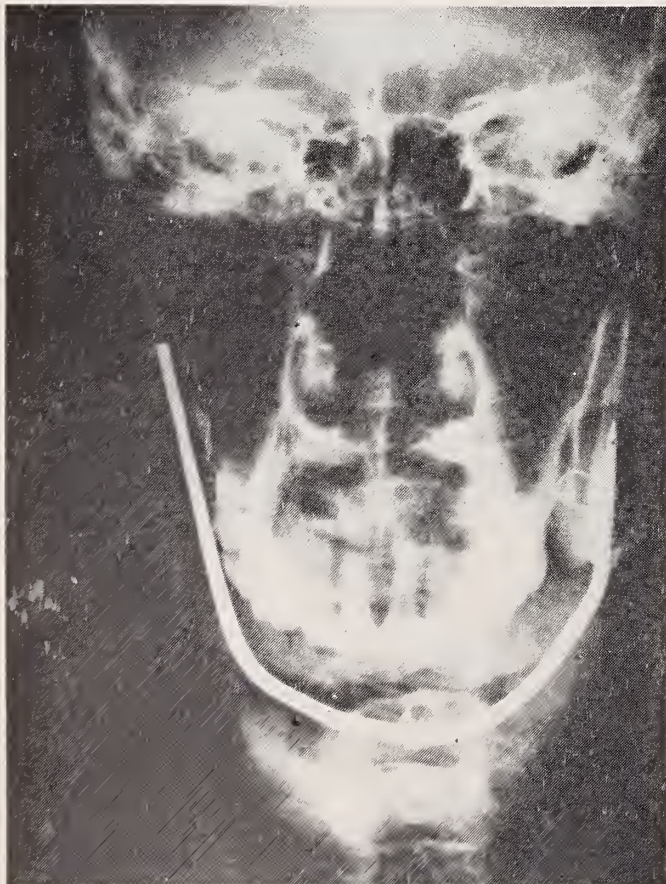


FIGURE 7: Case II. Immediate replacement of missing mandibular structure by Steinmann pin, closing the soft tissues of the mouth over the pin and suturing the genio-glossal muscles about the pin to assist in tongue control.

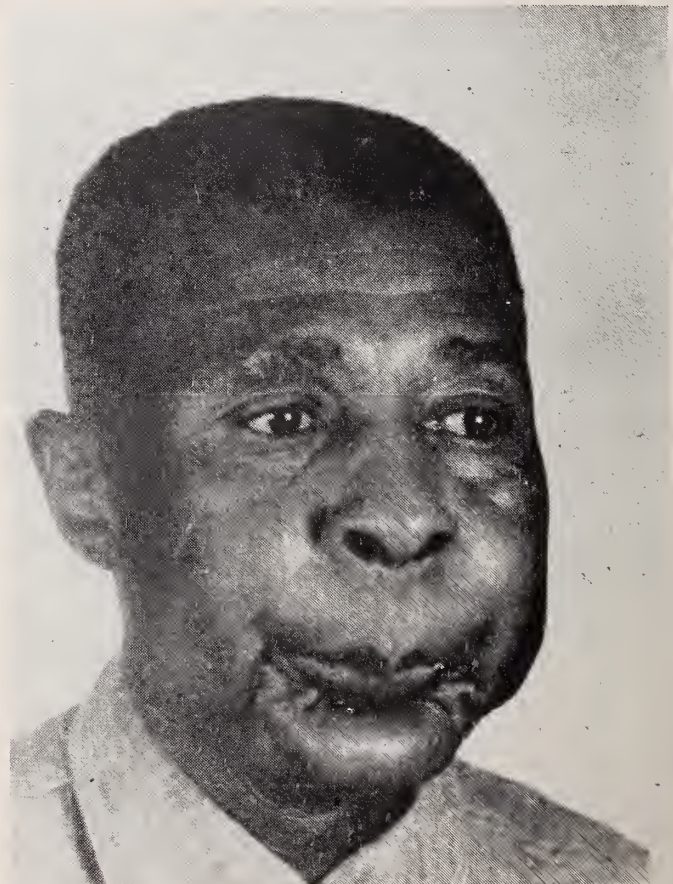


FIGURE 8: Case II. Postoperative appearance of the patient. An iliac bone graft was later done to rebuild the mandible but the pin was allowed to remain for additional support and it has stayed without producing any trouble.



FIGURE 10: Case III. Block excision of area including anterior wall of maxillary sinus. Outline of flap to be elevated.

FIGURE 11: Case III. Flap elevated and turned forward.



FIGURE 12: Case III. Flap rotated into defect and sutured. A small full-thickness skin graft from behind the right ear is used to close a secondary defect in front of the ear. An excess of flap along the anterior margin is left so as not to needlessly jeopardize the blood supply of the flap by removing it.

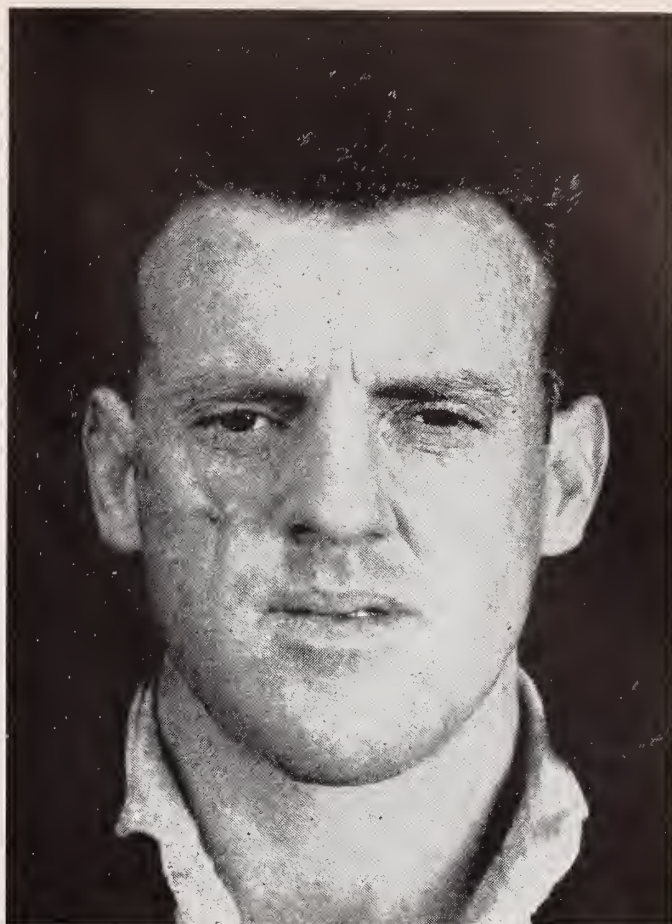


FIGURE 9: Case III. Recurrent squamous cell carcinoma of right cheek. Area had previously been excised, and he had received an unknown quantity of irradiation to the area with recurrence. Lesion is attached to anterior wall of maxilla and is firm and fixed.

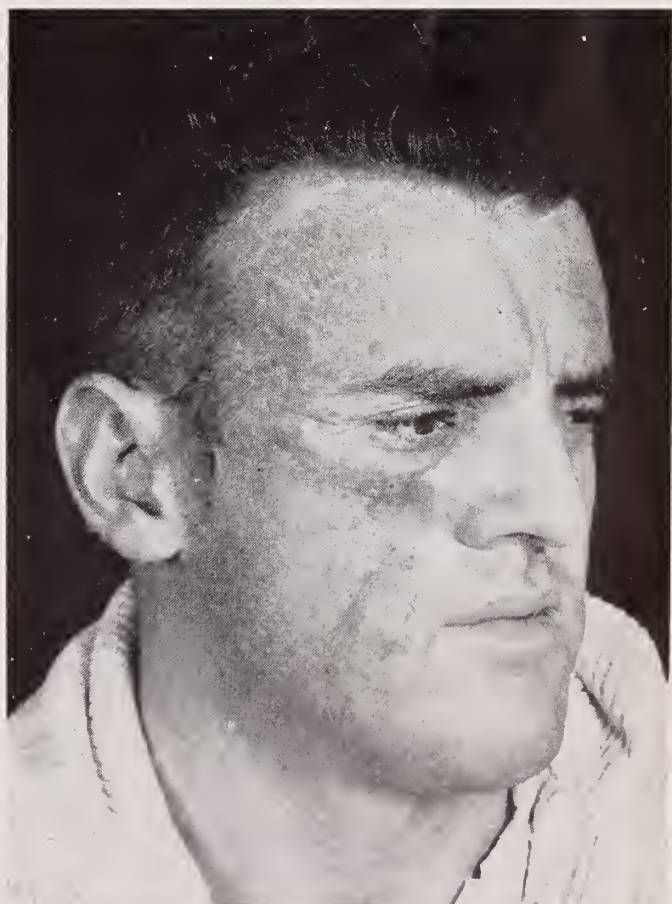


FIGURE 13: Case III. The excess flap was later removed under novacaine infiltration anesthesia. All areas healed.

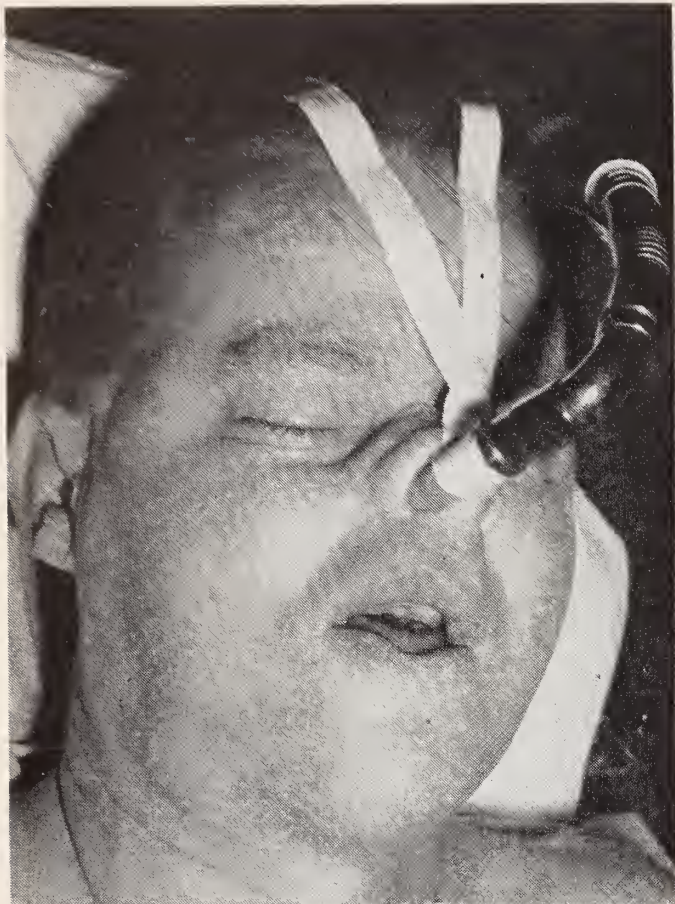


FIGURE 14: Case IV. Recurrent squamous cell carcinoma of lower lip.



FIGURE 15: Case IV. Full-thickness excision of right three-fourths of lower lip; flap of upper lip marked.

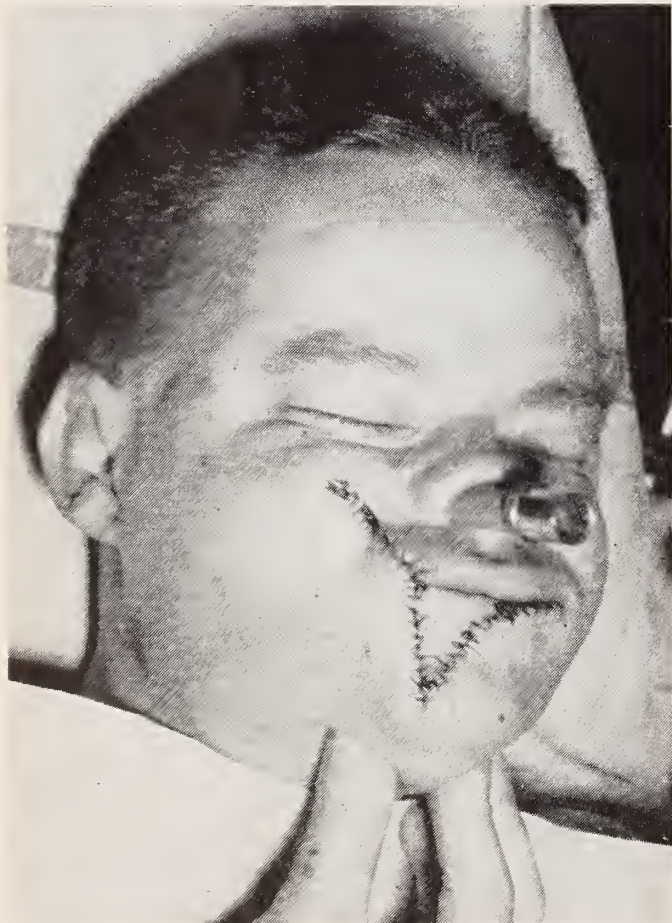


FIGURE 16: Case IV. Upper lip transferred into lower lip. Cutaneous surface of left side of lower lip excised and mucosa advanced to provide new vermillion border.



FIGURE 17: Case IV. Functional, water-tight mouth.

tissue was removed from the right nasolabial fold to further smooth the flap. This was done under novocaine infiltration anesthesia and was purposely left as a delayed procedure so as not to jeopardize the blood supply of the large flap which had been previously elevated. The man is free from disease and has a satisfactory cosmetic and functional result (Figure 13).

Lesions of the lip other than simple v-excision often require complicated procedures for reconstruc-

therapy, 4000 roentgens, with recurrence again. When first seen he had a lesion involving approximately one-half of the lower lip on the right side and an area of keratosis along the left side of the vermillion border with palpable, but not enlarged, submaxillary lymph nodes (Figure 14). At operation the entire right three-fourths of the lower lip and the



FIGURE 18: Case V. Excision of entire lower lip. Cheek flaps outlined.



FIGURE 19: Case V. Right cheek flap dissected free. Note mucous membrane attached to anterior edge of flap.



FIGURE 20: Case V. Closure after mobilization of both cheek flaps and advancement to the midline.

tion of these members. If the cheeks are in good condition or if the upper lip has not been used before, a portion of the upper lip can be utilized for replacement of the lower lip.

CASE IV

The patient was a 34-year-old man who had had carcinoma of the lower lip which had been treated by a v-excision with recurrence, followed by x-ray



FIGURE 21: Case V. V-Y closure of cheek with formation of functional mouth.

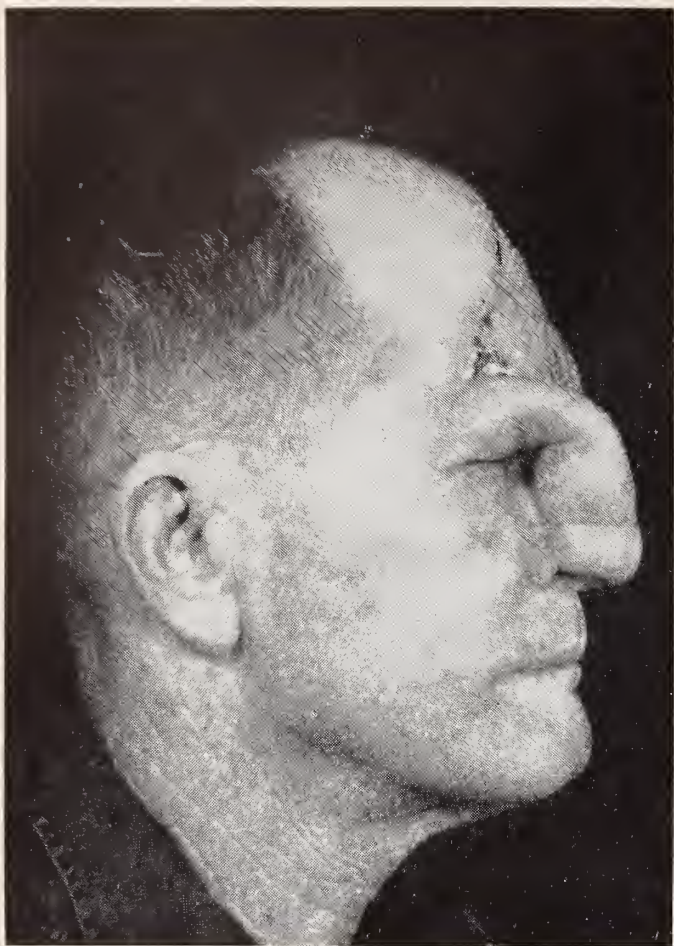


FIGURE 22: Case VI. Forehead flap turned down to reconstruct the nose after excision for squamous cell carcinoma.



FIGURE 23: Case VI. Nose reconstructed.

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vermilion of the left side were removed and the mucosa stretched over to form a new vermilion (Figure 15). The remainder of the lower lip was made by transferring a triangular portion of the upper lip to the lower lip on a small pedicle to maintain the circulation (Figure 16). At the conclusion of the operation the patient had a reconstructed mouth which was fairly tight, and at a later procedure the mouth will be enlarged to increase its dimensions (Figure 17).

CASE V

When the entire lower lip has to be removed, as in Case V (Figure 18), the lower lip can then be immediately reconstructed by means of adjacent cheek flaps. These flaps utilize the skin and subcutaneous tissue of the cheeks and the entire thickness of the cheek in the medial portion of the flap. The mucous membrane in the medial portion of the flap is then turned over the edges of the flap to form a new vermilion border and to form a lining for the inside of the lower lip (Figure 19), following which each flap is moved to the median line where it is sutured

to the opposite member and the defect of the cheeks closed in the form of a V-Y approximation (Figure 20). This gives a satisfactory, water-tight lip, and although it is somewhat thick, the appearance and function of the lip are good (Figure 21).

Not infrequently in cancers involving the nose, the entire nose or a portion of the nose has to be destroyed, but reconstruction can usually be very satisfactorily accomplished by means of forehead flaps in the method known as the "Indian rhinoplasty." This is usually done as a delayed procedure because the forehead is the most readily available source of tissue for nose reconstruction, and if recurrence of the nasal cancer should develop after repair, some distant tissue would have to be utilized for the later repair which would add to the difficulties of the procedure.

CASE VI

Case VI is a patient who had his nose reconstructed from a forehead flap with satisfactory cosmetic and functional result (Figure 22 and 23).

Full thickness or more extensive defects of the face can be improved, and the comfort of the patient can be increased by closing these areas with full

thickness flaps of skin and fat, lined on the inside to provide an epithelial surface for the flap in contact with mouth fluids. These flaps can be taken from the pectoral region, the arm, or the abdomen, depending on the size of the defect and the complexities of the problem.

CASE VII

This 30-year-old man's disease had begun some eight years previously with chondrosarcoma of the maxilla. He had had a number of operations for excision of the tumor, which gradually extended to the base of the skull and finally resulted in the defect shown in Figure 24. There had been no local recurrence of chondrosarcoma for four years. The left eye had been lost, the oral cavity was in plain view, and his method of closing this aperture was by packing it well with vaseline gauge with a large bandage to cover it, although the soiling of the bandage necessitated frequent changes. A large, lined abdominal flap was attached to his arm as a carrier and later moved to his face, where it was sutured in position around the margins, resulting in a permanent physiologic coverage of his face (Figure 25). The patient wears a denture and speaks normally, since the denture closes off the nasopharynx from the mouth cavity.

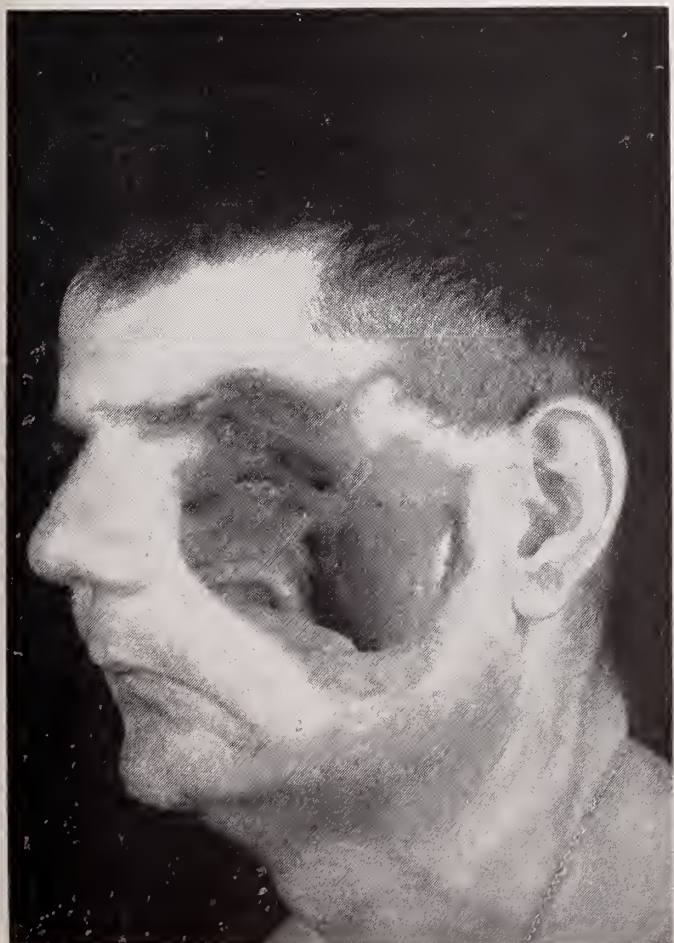


FIGURE 24: Case VII. Multiple operations for excision of recurrent chondrosarcoma.

Discussion

These few cases will illustrate that reconstruction of the face following the ravages of disease or surgical treatment of cancer is almost unlimited. It can be extended to benefit almost any patient who is desirous of having his features restored to some semblance of order after treatment or to improve the function of a part which had been lost by the treatment of the disease. The reconstruction should never jeopardize the adequate treatment of the cancer, however, and this, of course, is the primary problem in the handling of these patients.

Summary

It may be stated that adequate excision of facial cancers is a prime requisite in the treatment of this disease; that the effects of such treatment may usually be repaired, either primarily or secondarily; and that, finally, more satisfactory treatment of cancer of the face will depend on more vigorous treatment of the lesions as they develop, with the surgeon showing little fear of mutilating the individual. The fear of this mutilation can be largely dissipated by the knowledge that satisfactory reconstruction can usually be achieved when the disease is eliminated.

710 Peachtree Street, N.E.

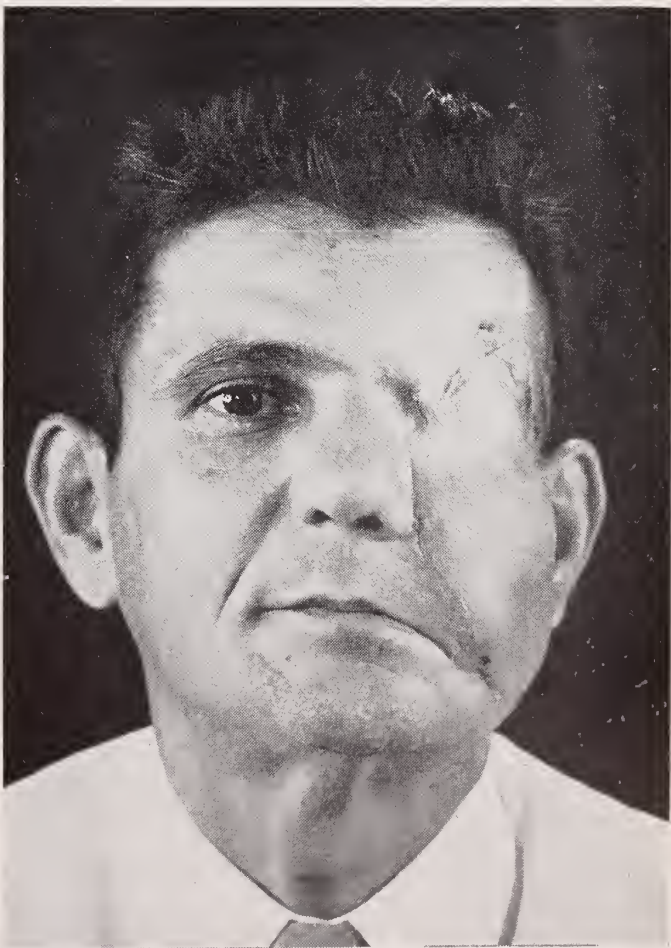


FIGURE 25: Case VII. Closure of the defect by means of a lined abdominal flap. The patient has a dental prosthesis and speaks normally. He wears a patch over the left eye.

ACUTE ENCEPHALITIS DUE TO INFECTIOUS MONONUCLEOSIS

FRED C. GOLDWASSER, M.D., D.D.S., *Alma, Georgia*

INFECTIOUS MONONUCLEOSIS is a fairly common disease, and the more serious complications of infectious mononucleosis do not occur very often. Involvement of the central nervous system occurs in less than one per cent of the cases. Definite encephalitis is even rarer than this; according to information received from the Public Health Service, there have been no cases of infectious mononucleosis encephalitis reported in the state of Georgia up to the present date.

It is the purpose of this paper to report a case of infectious mononucleosis encephalitis in which the history and symptoms led to a presumptive diagnosis of human rabies.

Case Report

H. B., an 18-year-old, white male first became sick on January 4, 1957. At that time he had a slight malaise. The next day he had generalized aches and pains with a low grade fever, and his throat began to feel a little sore. He came to the doctor's office on January 6, at which time the diagnosis appeared to be a case of flu. The patient was given the usual analgesics and sent home.

The patient did not improve. On January 7, he began to be very unsteady in his gait. According to other members of his family, he seemed to be getting irrational in his behavior and incoherent in his speech. Early in the morning of January 8, the patient suddenly had a generalized convulsion while at home. He was brought to the hospital immediately, arriving there at 7 a.m.

Examination at this time revealed the patient to be acutely ill. He was markedly excited and most unmanageable. At times he would suddenly stand straight up in bed and start screaming. He was extremely irritable and restless and completely uncooperative. He refused to swallow anything. When attempts were made to place a few drops of orange juice in his mouth, the patient spat them out very forcibly and violently. He did this with other liquids as well. It was difficult to determine whether or not this was due to a reflex spasm of the pharyngeal

A report of the first documented case of encephalitis secondary to infectious mononucleosis observed in Georgia.

muscles. The patient appeared to be hypersensitive to the slightest touch or even to the slightest sound.

The physical examination was conducted under the greatest difficulty; because of his hypersensitivity, the patient resisted all efforts at examination, and the neurological examination was necessarily incomplete. The patient's hyperactivity and restlessness made it obvious that there was no paralysis of any limb. Deep reflexes were hyperactive; no pathological reflexes were elicited. There did not appear to be any stiffness of the neck. The pupils were equal and did react to light. No muscular twitchings were noted. Management of the patient in bed was most difficult. He continued to resist all personal contact and on several occasions, he attempted to bite the individual who happened to be handling him.

The temperature on admission was 97.8°; The pulse was 88. Respirations were 20. The white blood count was 16,950. In the stained smear there were lymphocytes 38 per cent, monocytes six per cent, immature neutrophils two per cent, and mature neutrophils 54 per cent. No abnormal or unusual cells were found.

Since there have been numerous cases of rabies in animals reported in this county, the patient's family was questioned as to whether he had recently been bitten by an animal. There was no history and no direct evidence of any bite on him. However, there was a reliable report that the patient had handled a dead, mad fox several days previously.

The diagnosis on admission was possible human rabies. It was also considered that the patient might have acute encephalitis (influenzal type).

It was obvious that considerable sedation would be needed. Large doses of sodium nembutal and sparine were given intramuscularly from time to

time. Because of his refusal to accept any fluids by mouth, it was necessary to give glucose intravenously.

On January 10, the patient began to accept some fluids by mouth. It also became possible to reduce the amount of sedation. However the patient continued to be restless and negativistic. Moreover he still screamed when disturbed by the slightest touch.

On January 11, further improvement was noted. The patient still offered resistance to the slightest contact. However he was now much quieter when left alone than he had been. At this time, because of the improvement which had occurred, it was felt that the diagnosis of human rabies was no longer tenable.

A spinal tap was done. The fluid was clear and colorless. It was not possible to determine the pressure because of the agitation of the patient. The cell count was 13. The protein content was 116 mg. This seemed to indicate some type of acute encephalitis of viral origin.

On January 11, the heterophile agglutination test was done. It was positive in a dilution of 1:448. The guinea pig kidney absorption test was positive in a dilution of 1:224. The beef cell absorption test was negative in a dilution of 1:7.

On the basis of the above laboratory findings, the definite diagnosis of infectious mononucleosis with acute encephalitis was made.

The patient continued to improve slowly. On January 12, he was conscious and fairly well oriented although he had absolutely no recollection of the events of the preceding five days. He was still rather restless at times during the day. He still resented being disturbed in the slightest degree. He appeared to be somewhat apathetic and disinterested in his surroundings.

On January 14, another heterophile agglutination test was done. It was now positive in a dilution of 1:112. The guinea pig kidney absorption test was positive in a dilution of 1:56. The beef cell absorption test was negative in a dilution of 1:7.

On January 15, the patient was well enough to be discharged from the hospital. Complete examination at this time revealed only one neurological abnormality, a definite wrist drop on the left side. The patient no longer resented contact by nurses or aides. However, he was still rather lethargic and did not seem particularly interested in any sort of activity of his own.

On January 28, another heterophile agglutination test was done. This time it was positive in a dilution of 1:23. The guinea pig kidney absorption test was positive in a dilution of 1:14. The beef cell absorption test was negative in a dilution of 1:7.

Improvement has continued steadily. By February 1, 1957, only one sign was left of the patient's

illness, the left radial palsy. This is still present at the time of writing this paper, three months after the onset of the illness.

Comment

Until fairly recently, infectious mononucleosis has been regarded as a very mild disease with very few complications and with a consistently favorable prognosis. However, within the last 15 years, increasing note has been made in the literature of serious complications of this disease. In a number of instances, these complications have resulted in a fatal outcome.

Among the more dreaded complications is involvement of the central and peripheral nervous system. These neurological manifestations may occur very early or even quite late in the course of the disease. They may take the form of meningitis, encephalitis, poliomyelitis, or polyneuritis.

Almost any combination of neurological signs and symptoms can occur when the nervous system is affected by the disease. It may even fail to present any clear-cut neurological signs whatsoever and may show only a disturbance of behavior bordering on a psychosis.

Since the clinical picture produced by involvement of the nervous system by infectious mononucleosis may take so many different forms, heterophile antibody tests should be done on all patients with acute diseases of the nervous system in which the etiology is not readily determined.

The heterophile antibody test is almost specific in its action. The finding of agglutination of sheep cells in a dilution of 1:224 or more is presumptive evidence of infectious mononucleosis. Occasionally the agglutination test is not as clear-cut as one might wish because of the presence of agglutination in only the lower dilutions or because of the possibility of horse serum sickness. In these instances certain additional procedures are used. The guinea pig kidney absorbs the antigens produced by serum sickness. The beef cells absorb the antigens produced by infectious mononucleosis and by serum sickness. Careful analysis of these additional agglutination tests helps clarify the picture and provide a more definite diagnosis.

The author wishes to express his appreciation for the assistance and advice provided most graciously by Dr. William Axel Smith of Atlanta, and by Dr. T. F. Sellers of the State Health Department.

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Continued on Page 382

Case Report

CONGENITAL AGAMMAGLOBULINEMIA

An infant in whom this diagnosis was confirmed has done well on a regimen of regular gamma globulin injections.

GRADY E. BLACK, M.D., *Griffin, Georgia*

SINCE BRUTON¹ REPORTED the first known case of agammaglobulinemia in an eight-year-old boy in 1952, there have been a limited number of these cases of errors of gamma globulin in metabolism reported. Using electrophoresis, a great deal of study of blood components has been made. Two types of agammaglobulinemia were found: congenital and acquired. The acquired type can result from anything that inhibits formation or that causes excessive loss or excretion of this protein substance. An example may be in young infants², in whom the cause may be immaturity of the liver and other organs having to do with the formation of gamma globulin. There may be inadequate absorption in some nutritional states. Gamma globulin may be lost from the body in severe burns, lipid nephrosis, and other conditions where excessive amounts of protein leave the body. With the consequent loss of gamma globulin, the antibodies which are carried in this protein fraction are decreased, as in hypogammaglobulinemia, or absent as in agammaglobulinemia. This makes an individual more susceptible to infection. To the present time there have been only 30 cases of congenital agammaglobulinemia reported in the literature. The case below represents congenital agammaglobulinemia, and this paper will deal primarily with that type.

CASE REPORT

Willis H., age two and a half years, was delivered in a hospital in another city after a normal term pregnancy which was the mother's first. The birth weight was 6 pounds 14½ ounces. He was first seen in the office at the age of three weeks because of cramps and loose bowels. His formula was evaporated milk which did not seem to agree with him. He was put on Similac but continued with cramps and loose bowels. The formula was then changed to Mull-soy, on which he seemed to do well. After three months, attempts were made to get him to take solids, but he refused them. At times he would have some eczema and loose bowels. In May 1955, at the age of one year, he began to have frequent

U.R.I.'s, and his ears became infected on many occasions. These throat and ear infections were quite frequent but responded to penicillin. At times tetracycline proved helpful. Because of diarrhea resulting from oral medication and almost weekly attacks of throat infections, prophylactic injections of long acting bicillin were given every two weeks. He did show some improvement under this regimen.

In December 1955, a serum electrophoresis was done, and the report was agammaglobulinemia. He was started on monthly injections of five cubic centimeters of gamma globulin intramuscularly. Each month he would do well until just before time for another gamma globulin injection. In April 1956, he had a prolonged and resistant attack of fever, throat and ear infection. In May he did well, but in June 1956, he had two throat infections. Blood studies and urine studies were performed on July 17, 1956, while he had a throat infection. Results—hemoglobin: 11.5 grams; W.B.C.: 13,700 with 28 per cent polymorpholeukocytes and 72 per cent lymphocytes. The urine was negative. He was put on Chloramphenicol. He continued to run a low grade fever so he was admitted to the hospital for a complete study. The following is the complete laboratory study:

7-23-56—Urinalysis: clear yellow; reaction: 5.5; albumin: negative; sugar: negative; specific gravity: 1.025; microscopic: occasional WBC.

7-23-56—Blood count: hemoglobin: 10.8 grams; R.B.C.: 3,760,000; W.B.C.: 6,900, polys: 6%; lymphs: 93%; eosins: 1%; segs: 6%. (R.B.C.'s appeared to be hypochromic.) Sedimentation rate: 2 mm. in one hour and hematocrit: 37 mm.

7-23-56—Agglutinations: negative; C-reactive protein: negative; anti-streptolysin O titer: negative.

7-23-56—Blood gammaglobulin determination: agamma or hypo gammaglobulinemia.*

7-24-56—Blood count: hemoglobin: 9.7 grams; R.B.C.: 3,500,000; W.B.C.: 6,350; polys: 16%; lymphs: 82%; monocytes: 2%; reticulocytes: 0.4%; and platelets: 185,000.

7-24-56—Heterophile antibody test: negative.

7-24-56—Stool examination: negative for blood, starch, fat, trypsin, ova, and parasites. Pinworm: negative.

7-25-56—Blood culture of 7-23-56: negative.

7-23-56—First strength tuberculin: negative.

7-27-56—Second strength tuberculin: negative.

* Performed by Communicable Disease Center, Chamblee, Georgia.

7-23-56—X-ray of chest revealed no definite cardiac or pulmonary pathology.

7-30-56—Schick test: positive.

7-30-56—Blood type: B-RH positive.

This child was continued on gamma globulin, but doses of five cubic centimeters were given every two weeks. Since this regimen of therapy was instituted he has done well except for a moderately severe common cold in September.

Discussion

Congenital agammaglobulinemia certainly occurred in years before 1952; however, the individual who had this disease generally succumbed to some infectious process for which the child or infant had little or no resistance. Prior to sulfonamides and antibiotics,

this time. Possibly this is due to some transmission of protective antibodies from the mother which wanes about this time. The body does have the remaining elements of protection against infections. A polymorphonuclear leucocytosis⁴ occurs generally during infections, indicating some effort by the body to fight infection.

It has been noted that there is a deficiency of lymphoid tissue present in this disease. The adenoid tissue generally is small or absent, which is helpful at times in making the diagnosis.

Usually the individual reacts in the normal manner to viral infections, although there seem to be some exceptions to this, as noted by progressive vaccinia by Kozin and others.⁵ In most cases permanent

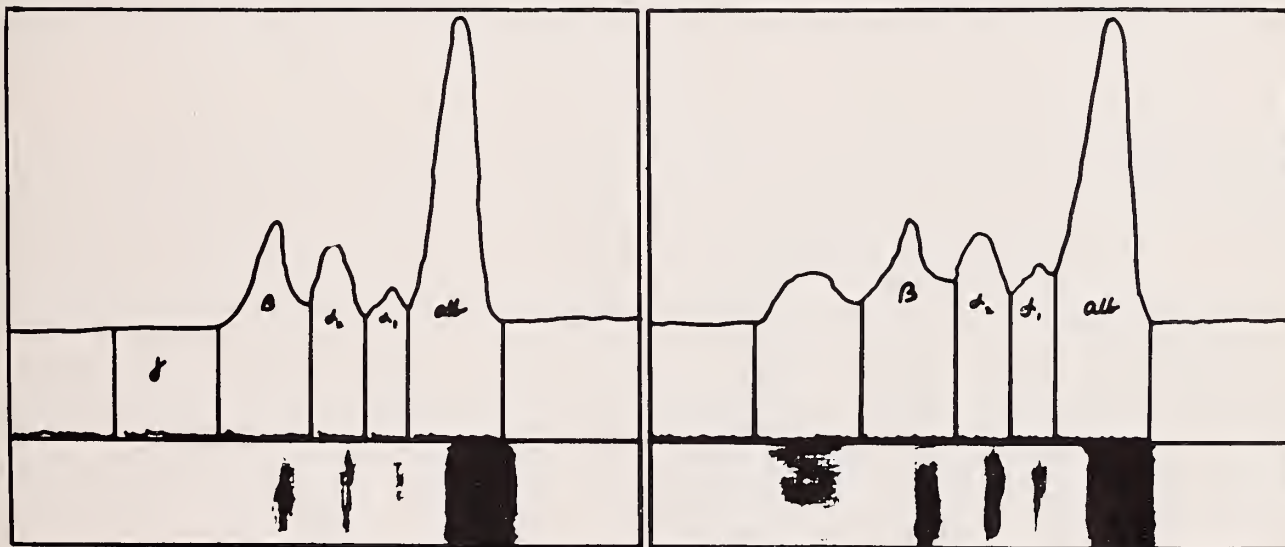


FIGURE 1: Electrophoretic pattern of the serum proteins is shown above.

some of the mortality of infants and young children could be attributed to this deficiency. Since antibiotics have come into use there have been infants who survived because of their getting to a physician early enough and because of the armamentarium of drugs which we physicians now have at our disposal. It is felt that most physicians can recall some infant or child who had very frequent infections for which a definite reason could not be established. This has been a puzzle, but now the shades of misunderstanding of many disorders of metabolism are being raised by the advances of our modern laboratories as well as various experiments in this interesting field of medicine. Electrophoresis specifically has been a valuable asset in making diagnoses which previously were obscure.

Congenital agammaglobulinemia is an inborn error of metabolism of the gamma globulin fraction of serum protein. This is a recessive trait transmitted from the maternal side as in hemophilia. It similarly occurs only in males. Typically the infant does fairly well for about nine to 12 months and then frequent bouts of infection begin. For some unexplained reason they have some protection prior to

immunity is produced in measles and other viral diseases. It is thought, however, that even minute quantities of antibody or gamma globulin can ward off attacks of virus infections as noted by the relatively small doses required in prophylactic immunization for measles.

The most frequent types of infections are respiratory; hence some children are prone to develop bronchiectasis.³ Others have recurrent meningitis, septicemia, bacterial intestinal infections, pyogenic skin infections, and the like.

Agammaglobulinemia may be diagnosed easily by certain laboratory tests which we now have at our disposal. With a young child who has repeated infections, one or more of these tests may be performed to determine the presence or absence of gamma globulin. The Kunkel's turbidimetric method would show a zero or insignificant turbidity reading with agammaglobulinemia. Determination of isoagglutins would be helpful by demonstrating absence of the reactions with the specific antiserum. Bone marrow smear can give a presumptive evidence of agammaglobulinemia since there is a complete absence of plasma cells found in bone marrow of

AGAMMAGLOBULINEMIA / Black

individuals with this disease.⁷ One of the easiest and simplest tests for checking on agammaglobulinemia is to perform a Schick test on one who has previously received immunization inoculations against diphtheria. A positive Schick test should make one suspicious enough to do further studies.

The final diagnosis of agammaglobulinemia must be determined by electrophoresis of the plasma or serum. This test is done in special laboratories, but it can easily be performed in any laboratory provided the equipment is available. The determination reveals accurately the presence or absence of gamma globulin.

Treatment of agammaglobulinemia consists of prophylaxis of infections. This may be done by avoidance when possible of any contact with anyone with an infection. Adequate injections of gamma globulin which usually last 25 to 30 days is the preferred manner of preventing infection. If 0.3 cubic centimeter of gamma globulin per pound of body weight is injected intramuscularly every four weeks, one should expect maintenance of the serum level above 100 mg. per cent. This is adequate to protect against most infections. Because of the shortage and expense of gamma globulin, prevention of infection may be attempted by prophylactic antibiotic therapy. The outlook for a patient with agammaglobulinemia is good as long as adequate prophylaxis is carried out. However, the long range effect of these efforts and the prognosis in these cases will be better known as we gain more experience in the treatment of this disease.

Comment

In the case reported the child as an infant manifested an allergy. These manifestations were intestinal cramps, mucus diarrhea, and eczema. There are tissue antibodies which act independently of serum gamma globulin; therefore, one may find some tissue antibody in the presence of agammaglobulinemia.

Because of the allergic symptoms of this infant, a diet consisting mainly of soy bean milk was given from the time he was a few weeks old until now. This infant, for a long period of time, refused any

food except the soy bean milk. Since soy bean milk has less methionine than cow's milk, it was felt that some nutritional deficiency could account for the lack of gamma globulin in this child. However, it has been shown by Mendel⁸ that optimal growth and development of an individual could be sustained on a more inferior protein substance, if adequate quantities of the substance were consumed.

A survey of the child's family history failed to reveal anyone who may have had agammaglobulinemia.

The trace of gamma globulin found in the second electrophoresis could be from the gamma globulin that he had been receiving prior to this study on him. It is strongly felt that this case represents congenital agammaglobulinemia rather than hypogammaglobulinemia or an acquired type of agammaglobulinemia.

Summary

A case of congenital agammaglobulinemia is presented and discussed. Various aspects of this infrequently seen disease are reviewed: namely, the increased susceptibility to bacterial infection and the absence of gamma globulin from the serum. The methods of diagnosing this disease are given. It is recommended that this disease or related conditions be considered in any case when very frequent bacterial infections occur in an individual.

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HEMANGIOMA OF THE COLON

A palpable mass and other hemangiomata involving the skin or other organs may suggest the diagnosis, but the X-ray examination is the only means for establishing the diagnosis on firm grounds prior to surgery.

HERBERT M. OLNICK, M.D., J. P. WOODHALL, JR., M.D.,
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THE PURPOSE OF THIS PAPER is to report the third hemangioma of the colon diagnosed by x-ray examination and surgically removed. Hollingsworth¹ and Bailey et al² have reported similar cases. Hemangiomas should be included in the differential diagnosis of intestinal lesions which produce obstruction or bleeding.

CASE REPORT

This 27-year-old white female was first seen in April 1956 complaining of intestinal bleeding. She was in the fourth month of her second pregnancy. Her complaint was that she had had several large, painless, bloody bowel movements. A similar episode had occurred one year previously during the fourth month of her first pregnancy.

Physical examination results were negative except for the pregnant uterus. Proctoscopic examination

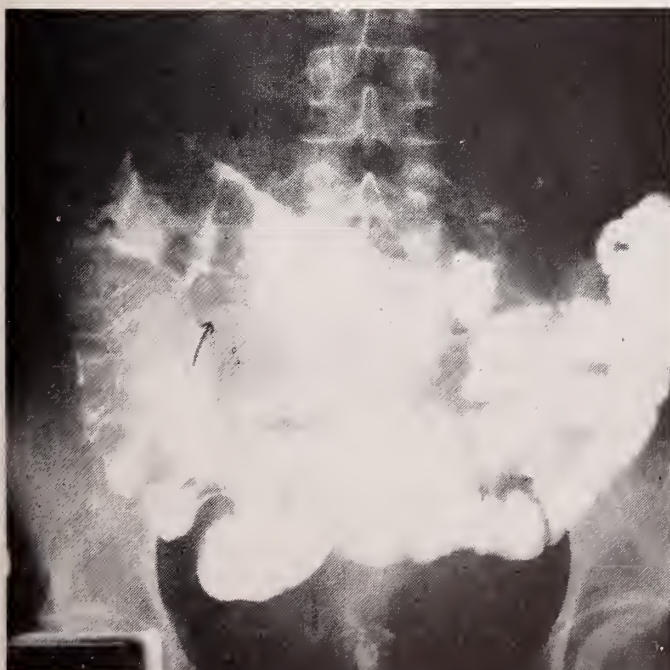


FIGURE 1: Barium enema examination discloses a prominent fold pattern in the proximal transverse colon with numerous phleboliths visible in the wall of the colon.



FIGURE 2: Operative specimen reveals numerous tortuous dilated blood vessels engorged with blood. The abnormal segment of colon merged indistinctly with the adjacent normal colon.

demonstrated old blood mixed with feces but no rectal lesion. On June 19, 1956, a barium enema was given. There were numerous phleboliths in the right upper quadrant, and the proximal transverse colon was narrowed.

The bleeding subsided, and in September 1956 she was delivered of a normal male infant.

On examination on October 31 an ill-defined soft mass could be felt in the right upper quadrant. Again colon studies revealed a large number of phleboliths associated with a narrowed transverse colon (Figure 1). After evacuation, the colon and phleboliths descended away from the liver shadow, indicating that the lesion was distinct from the liver.

At operation on November 16, the abdomen was explored. The right half of the transverse colon was replaced by a large, heavy, sausage-shaped mass completely obliterating the normal appearance of the colon. This mass was mobile and could be brought forth from the abdominal cavity (Figure 2). The mass felt doughy, and scattered over it in numerous

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places were grape-like clusters of dilated blood vessels resembling distended veins. The lesion did not involve any other organ. The mass with its mesentery was widely removed, and an end-to-end colocolostomy performed. The pathological report was hemangioma of the colon.

Discussion

Gentry et al¹ summarized the literature and the Mayo Clinic experience in a detailed review of intestinal vascular tumors. Many pathologists consider hemangioma as a hamartoma rather than a true neoplasm in that its growth potential is equivalent to that of the body, and its structures have no direct functional participation in the body as a whole. Gentry's classification follows:

Benign Vascular Lesions

A. Telangiectasis (hereditary and nonhereditary types)

B. Hemangioma

1. Capillary hemangioma (simple, mostly single)
2. Mixed capillary and cavernous hemangioma
3. Cavernous hemangioma
 - a. Multiple phlebectasis (small cavernous)
 - b. Simple polypoid (single cavernous)
 - c. Diffuse expansive (single contiguous)
 - d. Diffuse expansive (multiple non-contiguous)

Malignant Vascular Lesions

A. Hemangioendothelioma

B. "Benign metastasizing hemangioma"

C. Kaposi's sarcoma

D. Angiosarcoma

Cavernous hemangiomas may be sharply defined as in the polypoid variety which project out into the lumen, or they may be ill-defined as in the other types. They may be single or multiple. The surgically favorable varieties constitute about one-third of the total. Resection may be difficult or impossible if involvement of adjacent structures is extensive. Multiple hemangiomas may involve several feet of bowel either as numerous small hemangiomas or as several lengthy ones. Secondary changes from ulceration and infection may cause stenosis. Bleeding may be massive, occurring in bouts or may be detected only by chemical or microscopic examination of the feces.

Diagnosis

A palpable mass and other hemangiomata involving the skin or other organs may suggest the diagnosis, but the x-ray examination is the only means for establishing the diagnosis on firm grounds prior to surgery. Here one sees numerous phleboliths encircling a segment of the intestine. The lumen is usually narrowed and the mucosal folds have a bulky appearance produced by the dilated submucosal vessels. The phleboliths are characteristically uniform in size

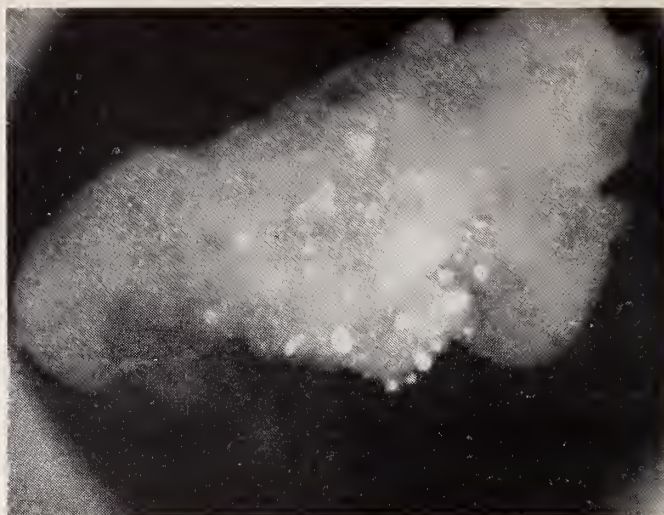


FIGURE 3: Radiograph of excised specimen. Note numerous phleboliths.

and appear round in cross section since they represent calcified, thrombosed veins. Their outer border is sometimes laminated.

One must differentiate phleboliths in a hemangioma from phleboliths occurring as an incidental finding in the mesentery and particularly in the pelvic veins. Tubercles and histoplasmin calcifications in the liver and spleen may be differentiated by their location and skin tests. Placental calcification usually has a more granular, closely packed appearance than the individual and spaced phlebolith densities of the hemangioma. Other causes of calcification can usually be differentiated without difficulty by their location and radiographic pattern.

The presence of phleboliths suggests that the lesion has been present for some time and points to a benign process. The phleboliths in this particular case outlined the overall size of the tumor (Figure 3).

Treatment

The treatment of hemangioma of the colon is primarily surgical since, even if the patient is asymptomatic, approximately 66 per cent will eventually develop symptoms. Certainly if obstruction or bleeding develops, surgical intervention becomes mandatory. If the lesion cannot be resected, sclerosing agents may be employed directly or radiation may be given post-operatively.

Summary

1. A third case of hemangioma of the colon is reported in which the diagnosis was made preoperatively by roentgen criteria.

2. The diagnosis was based on the roentgen findings of phleboliths corresponding in position to a palpable mass which involved the wall of the transverse colon.

3. The pathologic lesion consisted of a single cavernous hemangioma which was surgically removed.

724 Hemlock St.

Continued on Page 386

MEDICAL GRAND ROUNDS

at Grady Hospital

THE FACULTY, *Emory University School of Medicine*

DR. J. WILLIS HURST: Once each month we will have Grand Rounds in the manner that we shall attempt today. That is, that the subject is known, that there is a patient available to demonstrate the subject matter, and the conference will be prepared in detail so that it can be published. The conference will be organized and the material edited by the medical resident. This year the medical resident is Craig G. Cantrell.

DR. CANTRELL: Today we are presenting a patient who has myasthenia gravis. We are very fortunate to have with us Dr. Herbert Karp from Dr. Raymond Adams' Laboratory at the Massachusetts General Hospital, Dr. Carl Pfeiffer, Chairman of the Department of Pharmacology at Emory, and Dr. Cecil Couves with the Department of Surgery. First, I would like to review briefly our experience with myasthenia gravis here at Grady Hospital. Our records indicate that during the past five years there have been only six patients hospitalized in whom the diagnosis of myasthenia gravis was made.

This may indicate our lack of ability to diagnose this disease unless it is quite severe. There were five females and one male; four patients were white and two, Negro. There was a wide range in the ages of onset, the youngest being eight and the eldest 64. There was one hospital death. No thymomas have been definitely demonstrated by x-rays at this hospital. One patient, a 26-year-old white female, had a thymectomy in Galveston, Texas, but the results were poor. This patient was subsequently admitted to this hospital on two occasions, requiring respirator care in both instances.

There was one patient with coexistent thyrotoxicosis. This was demonstrated with an elevated serum P.B.I. and an elevated radioactive iodine uptake. The diagnosis of myasthenia gravis was also clinically well established. This patient was treated for thyrotoxicosis satisfactorily, but still requires prostigmine therapy. One patient, age 18, had the onset of her myasthenia during the last trimester of her pregnancy. The delivery was uneventful. The child was well at birth, with good spontaneous respiration.

She has had one subsequent delivery which was equally uneventful, but it was necessary to maintain therapy throughout her pregnancy. That is the essential information regarding our experience here, exclusive of the patient who will be presented today.

DR. EMBREE H. BLACKARD, JR.: Mr. Rainey, a 42-year-old unemployed chef, entered Grady for the first time on December 23, 1956, with a chief complaint of weakness and dysphagia of four and one-half months duration. His symptoms began with ptosis of the right eyelid which was followed by weakness of jaws on eating, difficulty swallowing, nasal speech, and weakness of arms. He consulted a local physician who made the diagnosis of myasthenia gravis, and therapy was begun with mytelase and changed to prostigmine. He responded poorly, however, and when increased difficulty with oral secretions was noted, he was referred to the hospital for admission.

His past history was interesting in that a chest x-ray made in 1952 for anterior chest pain and cough revealed an anterior mediastinal mass. He received numerous x-ray examinations of this mass, and five and one-half months later, it was noted to have disappeared. He has had subsequent x-rays every six months because of being a food handler, and it has not reappeared.

Physical examination on that admission revealed a blood pressure of 104/60 mm. of Hg., pulse of 60 per minute, respiration 20 per minute, and temperature 99° F. The patient was a thin white male with a nasal voice who had difficulty in swallowing. There was ptosis of the right eyelid and diplopia was noted on lateral gaze. The pupils were dilated. The head could not be lifted from the bed and the patient could sustain the extended arms for only 30 seconds. The blood count was normal except for a slight leukocytosis. A urinalysis, throat culture, chest x-ray, and EKG revealed no abnormalities.

His therapy in the hospital consisted of penicillin, and prostigmine, and on discharge he was to receive mestinon 60 mgm. q. 3 h. and ephedrine sulfate 25 mgm. t. i. d. Relief was incomplete, and on discharge

he complained of a mild head cold.

He was readmitted to the hospital five days later with increased weakness, cough, dyspnea, fever, and evidence of pneumonitis in the right lung base. A chest x-ray confirmed the diagnosis of pneumonia. A leukocytosis of 20,000 was noted, and treatment was begun with tetracycline, penicillin, and I.M. prostigmine. The second day required larger and larger doses of prostigmine. Toward the night of the second day he had symptoms of drug toxicity with diarrhea and abdominal cramps, and was given atropine. The following morning the status of therapy with prostigmine could not be determined so he was given a tensilon test. He was given two mgm. intravenously and showed initial improvement over the next five minutes, and the remaining eight mgm. was administered. There was again initial improvement, but then rather suddenly before atropine could be given, he was noted to have complete respiratory arrest. He was given artificial respiration, a tracheotomy was performed, and the patient was put in a respirator. He remained in the respirator part of five days, being gradually withdrawn for increasing intervals of time and since that time has been out of the respirator and breathing normally. He has been reregulated on mestinon, one and one-half tablets every three hours, and is right now in as good condition as he has been since he has had the disease. He still has difficulty with his food toward the end of a meal, trouble talking after short intervals, and fatigability. Are there any questions?

DR. CANTRELL: Suppose we show the films.

DR. BLACKARD: This is the x-ray when he first came into the hospital on the second admission; it shows an increased density in the right lung base compatible with pneumonia. I believe the follow-up film here shows clearing of this density. He has no anterior mediastinal mass present at this time.

QUESTION: Do you have the old films?

DR. BLACKARD: No, we don't. They have been destroyed.

QUESTION: Do you know how many times he was re-x-rayed?

DR. BLACKARD: We have a record of five x-ray examinations. He says there were at least 10 more

unrecorded.

(At this time, the patient was presented.)

DR. KARP: I don't know whether Mr. Rainey remembers me.

PATIENT: Yes, I remember you.

DR. KARP: Actually I saw him first in 1952 when he came in here for his mediastinal mass and lymphadenectomy. In looking through the records at that time I believe I did make specific mention that he complained somewhat of easy fatigability. At the time this was quite compatible with the process that we were suspecting in his chest. I had just seen Mr. Rainey once before when he was in the respirator, and at the present time I think if he will bear with us for just a moment we can show some of the characteristic features of myasthenic facies which he demonstrates quite well.

First of all, the ptosis, which is asymmetrical. Just look right at my finger, Mr. Rainey.

(Patient demonstrates.)

DR. KARP: There is some weakness of the frontalis. When did he have his last mestinon?

ANSWER: Forty-five minutes ago.

DR. KARP: Actually, he is just about getting maximum effect now. Now close your eyes just as tightly as you can, very tight, very tight. All right, now show me your teeth.

(Patient demonstrates.)

DR. KARP: Motions quite good there. Now keep your lips pursed together just like this. Don't let me open them. It can be overcome with slight effort. Now put your hands out, Mr. Rainey, and spread your fingers. There is some beginning wavering of the right hand now, but now 20 seconds shows, I think, quite a good response to his medication. What worries you the most now?

PATIENT: Swallowing, chewing, and talking.

DR. KARP: About what time in the morning do you take your first tablet?

PATIENT: Six o'clock.

DR. KARP: When do you eat?

PATIENT: I eat around seven-thirty.

DR. KARP: So you take your tablet at six and you eat at seven-thirty. Then when you start eating how long is it before you get into difficulty with swallowing?

PATIENT: I think in about four minutes. Then I have to stop and rest three or four minutes.

DR. KARP: How about chewing itself, do you have any difficulty with your chewing?

PATIENT: Oh, yes, yes.

DR. KARP: And is that present when you first start to eat?

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PATIENT: No sir, it comes on chewing and talking.

DR. KARP: One other question, and then we will let you go back up to the ward. As you think about your disease as it began, what was the first real symptom that gave you trouble?

PATIENT: My right eye began to droop.

DR. KARP: Just couldn't hold up the lid?

PATIENT: Yes.

DR. KARP: Did you at any time see double?

PATIENT: Oh, yes, I did along about the same time that it started.

DR. KARP: How long was it after your right eyelid began to droop that you noticed you had trouble with your chewing, swallowing, and talking?

PATIENT: About a week.

DR. KARP: And have you had any weakness in your arms and legs?

PATIENT: Oh, yes, my arms but not my legs. I haven't noticed it in the legs.

DR. KARP: When did your arms first begin to give you trouble?

PATIENT: Seems like the same time my chewing became weak. After I noticed my eye.

DR. KARP: All right. Does anyone else have any questions you would like to ask Mr. Rainey?

QUESTION: What about his cough, can he cough adequately?

PATIENT: Not all the time, no. I can't spit it up. I get a secretion in my throat.

DR. KARP: Once the secretion gets in your throat you still have trouble getting it out?

PATIENT: Getting it out, yes, at some times. Sometimes I can. I can lie down and lie there a few minutes and my eye opens up at times whether I am taking medicine or not.

DR. KARP: You can still get improvement just by resting?

PATIENT: Just by resting.

QUESTION: Could we ask him one thing. At the onset of the disease some six months ago was there any precipitating factor, anything that seemed to bring it on or did it come on gradually and spontaneously?

PATIENT: It came on gradually. My eye, like I say, just started drooping a little more and more.

DR. KARP: You hadn't a cold or anything like that?

PATIENT: No.

DR. KARP: Working every day?

PATIENT: Yes, I continued to work for about two months after it started.

DR. KARP: Thanks a lot for coming down here,

Mr. Rainey.

(Patient excused.)

DR. KARP: From the standpoint of a clinical discussion of myasthenia gravis, I believe if we just keep Mr. Rainey well supplied with mestinon and let him talk, he could give us as much information as we really need. The story as he presented it briefly was quite classical in characteristics, in fact, so much so that you wonder if Mr. Rainey hadn't gotten hold of someone's neurological textbook.

It has become, I think, well established protocol in any conference dealing with myasthenia gravis to initiate the discussion with a bit of a historical sketch, once more proving the well known fact that there is very little new in medicine. Willis, in 1685, in a treatise in which he discussed palsies, described a group of cases, and I think his description is so good that it bears actual verbatim reading here.

He states, "There is another kind of this disease depending on the scarcity of the spirits in which the motion fails wholly in no part or member yet is performed but weakly only or deprivedly in all. Those who being troubled with the scarcity of spirits will force them as much as they may to locomotion or are able at first rising in the morning to walk, move their arms this way and that or to lift up a weight with strength. But before noon the stores of the spirits which influence the muscle being spent, they are scarcely able to move hand or foot. I have now a prudent and honest woman in cure for many years who had been obnoxious of this kind of bastard palsy not only in the limbs but likewise in the tongue. This person for some time speaks freely and readily enough but after long, hard or laborious speaking, presently she becomes mute as a fish and cannot bring forth a word. Nay, and does not recover the use of her voice until after many minutes."

So, fundamentally, there is very little that can be added to the general clinical description of myasthenia gravis as presented by Willis. The rhetoric, the style is a little strange to us but other than that his clinical observation was quite perfect. But there are some characteristics of the clinical picture and of the course and natural history of the disease that are worthy of emphasis, are of considerable assistance in establishing the diagnosis of myasthenia gravis, and in actually managing a patient with myasthenia; and lastly, there are some that assist us quite a bit in speculating as to the basic, underlying defect in neuromuscular transmission in these people.

By far the outstanding feature of the weakness in myasthenia gravis is just what Mr. Rainey alluded to. That is, the fact that there is a definite relationship to the activity of the muscles. That is well known by all of you but I think worthy of re-emphasis. After a series of repetitive or prolonged contractions of a muscle group, the power of contractility in that muscle group rapidly diminishes, and then on rest they may, but not necessarily, recover. Further, the fatiga-

bility or the weakness has several other features. It is not attended by local pain or tenderness, and activity in one muscle group doesn't produce any weakness in other muscle groups which have not been specifically involved in that given act.

Thus, we can say definitely that the weakness of myasthenia gravis is characteristic in that it does not conform to the criteria that we, in our everyday parlance and on the wards, would call fatigue. There is no local pain and there is little feeling of fatigue.

The initial episode may appear quite precipitously, and because of its precipitous onset may well be labeled as a vascular abnormality or a vascular accident of some sort involving the central nervous system. Its tendency to affect the structures innervated by the brain stem nuclei, the tendency to occur in the young and middle-aged patient, its capricious nature tending to have exacerbations and remissions frequently leads one in the early stages of the disease to a process such as multiple sclerosis. There are certain features which, even at the onset of the disease, I think, are quite helpful in making you think primarily of myasthenia gravis.

Mr. Rainey, once more, is classical in this respect, and, that is, that in essentially all patients with myasthenia gravis, if they are carefully questioned and carefully examined there will be some signs and symptoms which are specifically referable to the eyes. Furthermore, one-half of all cases of myasthenia gravis which may proceed to become generalized, have as the onset to their illness difficulty with the ocular musculature, and they express themselves either as ptosis or diplopia. The ocular manifestations themselves may be unilateral, or they may be bilateral. They may vary from day to day. They can involve any of the extra-ocular musculature in any conceivable combination. They also involve the musculature of the lids.

There are some features of the involvement of the eyes in myasthenia gravis that should definitely be touched upon. First of all, the pupils, along with other smooth muscles of the body, are spared in this condition. Second, visual acuity itself and visual fields are also spared. The one point that is quite definitely important in examining the extra-ocular musculature in the lids of a myasthenia patient is the fact that when first seen, one is struck immediately by the ptosis, by the weakness of the levator muscles of the lid. However, in the vast majority of patients with the ptosis, an examination will reveal, as it did also in Mr. Rainey, that there is concomitant weakness in the orbicularis oculi muscles, and the patient not only has trouble keeping his eyes open, but he has trouble closing them. This is one clinical axiom with regard to the extra-ocular and lid difficulty of myasthenics, that is, where there is weakness

in both opening and closing the eyes one should certainly think of myasthenia gravis or specific disease of the extra-ocular muscles such as dystrophy.

Once the disease has appeared it may follow several patterns. First of all, there may be a gradual, insidious progression of the disease to involve extensive areas; this in turn, being followed by a steady state with or without definite remissions in the disease. The second course is one of going from beginning ocular symptoms to a rapid progression and extent in severity which eventuates in death, frequently within a matter of a few months. These two courses I think can be grouped together as representing instances of generalized myasthenia gravis. The third pattern is that the ocular manifestations may be the only manifestations of the disease for many years. This category is also unique in that there is an increased incidence of spontaneous remissions.

As a prototype for the clinical course of myasthenia gravis I know of no better study group of patients than those out of Johns Hopkins studied by Jones and McGhee Harvey. In their last publication they had followed some 270 cases of myasthenia gravis, 220 of which were classified as the generalized type. Of those who had a generalized onset of their myasthenia gravis, 40 per cent had spread to widespread involvement within one month, and of those who had their ocular manifestations at the onset, 50 per cent of them extended to become generalized in one to six months. Seventy-five per cent of the total that began as ocular became generalized in six to 12 months. An additional 10 per cent extended in two to five years and an additional 10 per cent in six to 24 years.

So you can see that a patient who has localized ocular myasthenia gravis, who has maintained this state for a period of five to six years, has an excellent chance of not going beyond that point throughout the rest of his life. Now this is an extremely important point: quite obviously from the standpoint of prognosis, his disease is localized in an area which is troublesome, certainly, but is certainly not life endangering; and one can afford to temporize and manage the man quite conservatively. In addition his chances of having spontaneous remissions are somewhat greater if he falls into the group of ocular myasthenia.

Just a word or two about the spread when it does occur. The disease characteristically begins in extra-ocular musculature, then spreads to involve the face and in that area involves the lids, then frontalis, then the lower facial musculature, giving the patient a characteristic myasthenic facies (flattening of the naso-labial folds), following which is difficulty with use of the tongue, difficulty with speech, difficulty in

swallowing, then difficulty in the neck musculature. The next area affected includes the limbs, the upper extremities being involved first and the lower extremities later. This is what Mr. Rainey reports. Trunk, abdominal, and respiratory musculature actually in the natural history of the disease are late areas of involvement. We didn't ask Mr. Rainey specifically if before therapy was begun he had any difficulty with his respiratory movements, but these actually are late and grave prognostic signs, of course.

As I alluded to previously, the course of the disease is not one of an inexorable downhill progression. There are spontaneous remissions which are the only things that the patient has to look forward to, and they are the bane of the existence of the man who tries to evaluate specific therapeutic measures in myasthenia gravis. Approximately a quarter of all the patients in the Hopkins series had a complete or a nearly complete reversal of their disease for periods of at least six months, the average period of remission being about five years. The peak of remissions was about four to five years after the onset of symptoms of myasthenia gravis. The one population group that stands out as being more likely to be blessed by a spontaneous remission is the young female under 40 years of age.

Now I mention these things specifically because I think that in considering the patient such as Mr. Rainey—and we certainly should bring these points up later after everyone else is heard from—one should try to pigeonhole him with regard to what type of disease he has. So at this point I would say that certainly his weakness became widespread within one to six months and that his disease became quite incapacitating. Being a male and having the onset of his disease in late middle life tends to place Mr. Rainey in a group with a definitely unfavorable prognosis.

Time really doesn't permit too much of a discussion with regard to some of the other factors which play a part in the disease. First of all, pregnancy. The classical interrelationship between myasthenia gravis and pregnancy is one of slight worsening in the first trimester and definite improvement during the remaining part of the pregnancy. Following delivery for one to two weeks in the immediate post partal period there may be definite clinical worsening. This, I like to stress, is not characteristic enough to be used diagnostically, nor can you just relax and say that this patient is going to get better as she delivers. One thing is quite definite: myasthenia is not an indication for interruption of labor and labor itself usually proceeds quite well if one is aware of the fact that he is dealing with a patient with myasthenia gravis and takes proper precautions.

The other point is that of coexistent diseases. I

think the one horse that everybody has been riding quite long and hard is that of coexistence of thyrotoxicosis. There are certain features of the myasthenia of thyrotoxicosis that are highly suggestive of those that are seen in myasthenia gravis. But I think we can dispose of this by saying that pharmacologically, thyrotoxicosis and myasthenia gravis appear to be quite independent diseases.

I have purposely avoided any discussion of drug therapy or any of the specific drugs available for the diagnosis of myasthenia gravis. I think that after Dr. Pfeiffer presents his data we can hear from the thoracic surgeons and perhaps arrive at some definite course for the management of myasthenia gravis, particularly with regard to treating Mr. Rainey.

DR. CANTRELL: Thank you, Dr. Karp.

I would now like for Dr. Pfeiffer to talk to us about the chemotherapy and physiology of this disease.

DR. PFEIFFER: It is perhaps noteworthy that there have been only six cases diagnosed as myasthenia gravis at Grady in the last five years. At Hopkins, where they have a group interested in this disorder, there have been over 200. A man in Indianapolis has a group of 150 to 200 which he treats. One is impressed, then, that the interest in the disorder makes it a less rare disease than one would expect from the admissions to Grady Hospital. In other words, we are undoubtedly treating the severer cases at Grady.

In regard to the eye muscles, one should point out that with any type of curarizing agent, the eye muscles (either the extra-ocular muscles or eyelids) are the first to be affected. In other words, diplopia is seen frequently with a dose of 500 mgm. of tetraethyl-ammonium, a mild curarizing agent. The eye muscles essentially are more sensitive to a curarizing agent. From the standpoint of the etiology of the disease, it is amazing that we know as much as we do about acetylcholine, choline, and its synthesis and breakdown in the body and still do not have a clear-cut answer for the treatment of myasthenia gravis.

In the case of the muscle we know that the neuro-humor which transmits the nerve impulse is acetylcholine, which we can abbreviate by Ach. The classical story is that this comes from choline by acetylation; that there is a choline-esterase which proceeds to break Ach. down into acetic acid and choline after it has served its purpose of transmitting nerve impulse to the motor end plate.

We know from the data in the literature that the choline-esterase is normal in the muscles of the myasthenic patient. We also know that he does not have an elevated plasma level of choline-esterase. One might suspect from the effect on the eyes that per-

haps an abnormal curariform compound circulates in the blood of the myasthenic to produce a curarizing effect on the muscles throughout the body. The best bet is that, in some way or other, acetylcholine is not made in sufficient quantities in the affected muscles. We do not have a simple biochemical test which can be applied to the serum or to the muscle biopsy for choline acetylase which is the enzyme which makes acetylcholine. McGhee Harvey and Garb have recently shown that part of the curarizing compound can be choline itself. In other words, as acetylcholine breaks down, the choline liberated has a curarizing effect. We know that excess doses of acetylcholine will do this and hence the unesterified choline is incriminated as the cause for the muscle weakness. One can, using the theory of the formation of acetylcholine, try various things in these patients. We know that in the case of thyroid there is an antagonism between thyroid and B-12, the red vitamin. We also know that one of the normal biochemical functions of vitamin B-12 is to methylate, so that the methylation of, say, ethanolamine which would be a precursor of choline, could be furthered by vitamin B-12. It is not well absorbed orally, so that one should try 100 micrograms intramuscularly daily in these patients to see if the further methylation would be helpful.

The actual enzyme which synthesizes acetylcholine is a coenzyme which contains pantothenic acid. We know that no one has described thus far a real deficiency of pantothenic acid in man; however, it is another drug which could be tried in the myasthenic. Its activity is due to a terminal sulfhydryl group, and this sulfhydryl group, in order to accept the acetyl, must be kept reduced. One of the functions of vitamin B-12 is to keep the coenzyme in the reduced state so there would be another reason then for trying the red vitamin B-12 in these patients.

One can use a curarizing agent at one-tenth to one-twentieth the usual curarizing dose to diagnose mild cases. The curare test should preferably be carried out with succinylcholine since the test is obviously dangerous. One can also use the effect of quinine which makes these myasthenic patients worse. An oral dose of quinine will make their symptoms worse for a period of two or three hours. One should use 300 milligrams (five grains) of quinine for this purpose. The treatment of the patient by means of anticholinesterase drugs or direct muscular stimulants has been more useful in the seriously ill myasthenic patient. One can use a half milligram of neostigmine (Prostigmine) intravenously, or 10 milligrams of Tensilon intravenously in order to get an immediate effect.

One is impressed with the crudeness of clinical methods for measuring muscle strength. The students

who took our course know that we have a grip-strength measuring device, and one can devise a very simple method and get a nice graphic curve of increase or decrease in muscle strength by merely having the patient blow up a mercury manometer with his lungs. In other words, you can then get a record in millimeters of mercury pressure of the force of their lungs and have a very nice drug action curve, a clinical pharmacological experiment instead of the rather crude methods which are sometimes used.

As far as prolonged therapy is concerned, we know that prostigmine bromide has been the mainstay. Some of these patients will require 350 milligrams a day, and when the prostigmine is used in such dosage they sometimes end up with bromide poisoning because of the amount of prostigmine they take. The methylsulphate may be used instead of the bromide to prevent this situation. Patients treated with the anti-cholinesterases tend to become overdosed unless watched carefully. At that time the jaw muscles will fasciculate. They will lose all of the gain, and this is the thing which brings the patient to a hospital after he has been controlled moderately well by the neurologist. The patient no longer responds, and he is put in a respirator. When the amount of prostigmine or tensilon or other drugs are decreased, he again responds to these drugs.

From the standpoint of more active and more prolonged cholinesterases the various war gases such as D.F.P. have been used, three milligrams twice a week intramuscularly. The effect in some patients has been good. Over a long period of time these drugs don't seem to be as good as the more druglike, short acting anti-cholinesterases. From the standpoint of other drugs, large doses of glycine and large doses of guanidine have been used in the myasthenic. Neither of these are to be recommended. Sometimes ephedrine in a dose of 10 milligrams three times a day is helpful, and occasionally they respond to potassium therapy, not the iodide but the chloride.

Neostigmine, tensilon, mytelase, and mestinon are at present the drugs of choice. The patient should keep a chart of his responses to aid the physician in regulating the dose.

DR. CANTRELL: Thank you very much, Dr. Pfeiffer. Since we have the history of a mass or a possible thymoma being present in our patient some five years ago, I would like to ask Dr. Couves from the Department of Surgery for his comment regarding therapy. I would like to get his opinions on the results of surgery in myasthenia gravis, and the results we might expect from thymectomy in Mr. Rainey. Dr. Couves.

DR. COUVES: It would appear that a Frenchman was the first man to remove the thymus. He performed this thymectomy in 1910. His patient, a

child, had what he called thymic asthma. Of course this was a very common diagnosis at this period of medicine. In our department, and I think throughout the country, we feel very strongly about the thymus of a child. We feel in children that the thymus should not be irradiated or removed unless certain indications are present. I am sure you are all aware of the reports from Chicago on the incidence of carcinoma of thyroid in children who have had irradiation to the neck.

It remained for the old German, Sauerbruch to do the first thymectomy for myasthenia gravis. I have not been able to find—perhaps Dr. Karp can help me—why he did this. It was through the cervical approach which we do not use any more, and the patient survived the operation. He did not do another one until 1936. Another German performed a thymectomy in 1917. Of course you are all familiar with Blalock's work in 1936. He removed the thymus for a tumor of the thymus, and the patient was relieved of her symptoms of myasthenia gravis.

I think it is very important as far as the surgery of myasthenia gravis is concerned, to eliminate those patients who have an associated tumor. We attempt in our department to eliminate these by tomograms and by accurate roentgenologic methods because there is no question in our minds that they represent an entirely different group than the so-called myasthenic patient without a tumor. Pathologically, in the diagnosis of these tumors the difficulty frequently arises as to whether they are benign or malignant. Even more important, at surgery we have difficulty at times in determining whether the tumor really does arise from the thymus gland. The differential usually being between a thymic tumor and a malignant tumor of the lung. It is apparently true that 15 per cent of the patients with myasthenia will have benign and encapsulated tumors. Seventy-five per cent of the patients with thymic tumors will have myasthenia gravis.

Now I think that we come to the most important thing as far as the surgery of this disease is concerned. We must realize that there is a well known remission rate. I think Dr. Karp has pointed out that the remission rate is usually for a short period of time. Some of Harvey's cases, however, had remissions of up to 16 years. The age of the patient may be a factor.

Dr. Karp pointed out that the older male especially is not a good candidate for surgery, but I think we must look to Sir Jeffry Keynes' figures on age. He has classified his results as A, B, C, and D, and in the analysis of his results according to age, he has found that age is not a significant factor. Of course the duration of the disease is of vital importance.

The longer it has been present, with or without the necessity for neostigmine, the worse the results with surgery will be.

I would say that there are three schools as far as results are concerned. There is the school centered around the Mayo group which has reported a very dismal future for the people with thymectomies. Possibly the group in Baltimore is in between, and Sir Jeffry Keynes, of course, on the other side of the Atlantic reports results up to 79 per cent satisfactory. Incidentally, in his most recent writings he reports on about 250 thymectomies. His results are based on only those cases where no evidence of a tumor is exhibited.

I think it is important that we discuss the preparation of a patient for surgery, because here again I think it is one disease where we must have adequate support from all members of every department, especially the internist who is interested in myasthenia, the anesthetist, the physiologist, and of course the surgeon. There must be no pulmonary infection. We know these people do not cough adequately after surgery, and practically every death that has been reported, especially in Sir Jeffry Keynes' series, has been due to pulmonary complications. We set up a rigorous breathing exercise regime for these people and bring them to surgery slightly dehydrated. There are two methods of preparing them for surgery with neostigmine, the continuous method which we favor, or the intermittent method. We have the patient stabilized before surgery. We figure out the best dosage of neostigmine required during the next eight hours and have it mixed up and started a half hour before surgery, supplementing it during surgery if the patient shows signs of getting into difficulty.

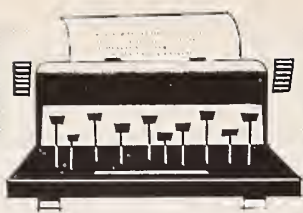
I suppose that we might conclude by combining the results that are available in the literature, and that we can probably expect 50 per cent of cases without a tumor to have a good result.

DR. CANTRELL: Dr. Couves, with regard to our patient, Mr. Rainey, since a mass was alluded to five years ago, how would that influence you in selecting him as a candidate for thymectomy?

DR. COUVES: Based on the statistics, if he does not have a tumor, and I presume he does not, his chances of getting a good result are reasonably good. Being an older male his result would not be as good as if he were a younger female. One of the favorable things is that his disease is of short duration. I would say offhand, based on the only available statistics that we have, that his results from surgery might be considered to be fairly good.

DR. CANTRELL: Thank you very much. Are there any questions or comments? If not, that concludes our Grand Rounds.

69 Butler St., S.E.



editorials

OCULAR TOXOPLASMOSIS

INFLAMMATIONS OF THE INNER EYE continue to perplex the ophthalmologist. Antibiotic and chemotherapeutic agents developed in recent years have no effect on the common varieties of iridocyclitis and chorioretinitis. This suggests that endogenous eye inflammations are not infectious in origin at all—or that they are due to bacteria, viruses or parasites which are insensitive to the new drugs.

Each of these concepts is a likely one. Very probably the iridocyclitis seen so commonly in connection with joint disease (rheumatoid arthritis, gout, Reiter's syndrome) is a manifestation of metabolic disturbance or hypersensitivity and so is not due to the presence of living organisms in the eye. On the other hand, chronic inflammations of both the anterior and posterior segments of the inner eye are occasionally caused by infections such as leprosy and leptospirosis and the larvae of worms, none of which are sensitive to the sulfonamides or antibiotics. However, these rare occurrences do not explain the chronic chorioretinitis seen so commonly in ophthalmic practice and therefore the search for their etiologic factors goes on.

The latest and most productive lead has been the discovery of parasites resembling *Toxoplasma* in histopathologic sections of numerous eyes removed because of chronic inflammation. Confirmation of this observation by other means is still lacking except that in one instance *Toxoplasma* has been isolated from an enucleated eye. Only a presumptive diagnosis of ocular toxoplasmosis can be made on the basis of positive serologic tests because of the frequency of infection in the general population. It is not likely that the problem of ocular toxoplasmosis will be solved until more is known about the generalized disease and the organism which is its cause.

Toxoplasma gondii is an intracellular parasite which is very widespread in nature. The organism

has been reported in many animals and birds—both wild and domestic. The source of human infection and the manner of its spread is unknown except in congenital cases. No effective treatment has been found for the human disease.

Human toxoplasmosis was first described in its congenital form. Recognition of fatal cases of the acquired disease soon followed. A fatal outcome in adults must be an extremely rare occurrence, however, since approximately a fourth of the general adult population shows serologic evidence of past infection by the parasite. Most cases of acquired toxoplasmosis must be symptomless or attended by such mild signs that they go unnoticed. Some grippe-like disorders may actually be manifestations of the acute phase of toxoplasmosis. In children "glandular fever" has occasionally been shown to be acute or subacute toxoplasmosis rather than infectious mononucleosis. Both acute and chronic states of the disease will come to be recognized with increasing frequency in the future. In the meantime toxoplasmosis should be kept in mind when unusual fevers are encountered.

Because toxoplasmosis is so widespread, it is not uncommonly acquired by pregnant women who then transmit the disease to their offspring. The full-blown form of the congenital infection is characterized by such signs of cerebral damage as hydrocephalus, convulsions, microcephaly, mental retardation and intracerebral calcifications seen on x-ray of the skull. The most constant finding, however, is chorioretinitis which typically is bilateral and tends to involve the macula. Incomplete syndromes are well known. There may be only chorioretinitis and intracerebral calcification or chorioretinitis and convulsions, and it is now felt that there may be chorioretinitis alone and this in one eye only and peripheral rather than central in location. Whether or not a congenital infection may be completely unapparent is not yet known. At any rate, congenital toxoplasmosis is not uncommon and should be suspected in children or adults showing any of the mentioned changes. Chorioretinitis is such a constant finding in proven cases that one can hardly make a diagnosis of congenital toxoplasmosis in its absence, but we will recognize additional cases if we remember that chorioretinitis may be the only sign of the disease.

John R. Fair, M.D.

SENIOR MEDICAL COURSE

THE MEDICAL PROFESSION has long been aware of the needed emphasis that must be given medical students in the broad non-scientific field of "the art of the practice of medicine." To that end the Council of the Medical Association of Georgia appointed a special committee of Council to investigate, recom-

mend, and prepare a course of study on this topic for inclusion in the curriculum of senior medical students at the two medical schools in Georgia.

This medical school course committee tentatively proposes a 10-week course of one hour per week to cover this area. Guest M.D. lecturers, whose experience was gained in actual private practice of medicine, would present talks designed to acquaint the senior medical student with the facts of actual medical practice on a number of subjects vitally necessary to the physician just beginning his practice. These talks would be mimeographed for the student for later use, and question and answer periods would serve to illuminate the subject matter.

Topics would include medical economics, medical ethics, medical organizations, hospital relations, medical insurance, etc. These lectures would serve as a guide for the many problems besetting the new practitioner and give the student an insight into the ethical and commonly accepted practices of his future colleagues. The course will orient the medical student to the "rules of the road" in the profession. Practice rather than theory will be emphasized, and the lecturer will speak with authority gained from the true test of experience.

The course is now being prepared by three physicians representing both general practice and the medical specialties from the point of view of the small community, the medium size town, and the large city. After completion of the course outline, articulate guest speakers will be chosen to present subjects with which they have particular facility. Speakers will be given a strict outline of the points to emphasize to exclude digression from the subject at hand. The two deans of our medical schools will assist in the preparation of the course to further assure its success.

This project is another activity of the Association to promote the art of medicine and the betterment of public health for the citizens of Georgia.

PHYSICAL DIAGNOSIS IN ARTERIAL SEGMENTAL OCCLUSION

ALTHOUGH ARTERIOSCLEROSIS is a generalized disease, it has been found that frequently it is localized to one segment of the vascular tree, the remainder being relatively free of the disease. Advancements in the field of vascular surgery during the past decade have made it possible to resect this obstructed segment and restore the continuity of the circulation with a homograft or synthetic graft.

The success of this procedure depends upon the selection of cases in which the disease is still

segmental in nature. It is in this regard that physical diagnosis is of the utmost importance. Early diagnosis and treatment are important since the disease might progress to occlude a vital vessel resulting in loss of life or extremity. In addition, surgery can be done with a higher success rate and fewer complications.

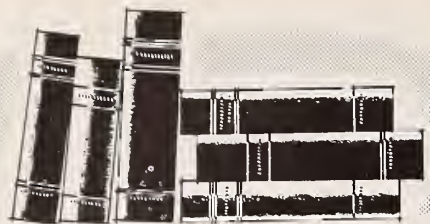
Clinically, patients with segmental arterial occlusion fall into a definite pattern, and by means of a careful history and physical examination, one can localize the site and extent of occlusion with surprising accuracy. Occlusion of the aorta and iliac arteries is accompanied by pain in the back and gluteal region and a tired sensation of the hips and legs after exercise which are relieved by rest. In the male, inability to maintain an erection is frequent. Occlusion confined to the common and deep femoral arteries causes pain after exercise, or claudication, in the thigh muscles. Superficial femoral artery occlusion is followed by the classically described claudication of the muscles of the calf of the leg. Multiple areas may be involved, in which event a combination of symptoms will be produced.

On examination all pulses below the level of a complete occlusion are absent. Absence of pulses is not necessary, however; a vessel may be occluded to the point of producing symptoms and the patient still have distal pulses. In this event the pulses will be markedly diminished, and there will be a systolic bruit and murmur distal to the point of stenosis; the greater the degree of occlusion, the fainter the murmur and the more feeble the pulse.

The most striking feature is a lack of trophic changes in the extremity expected in a patient with no pulses. These do not occur because the collateral circulation can re-enter the main vascular channel, distal to the point of segmental occlusion, and maintain an adequate circulation while the patient is at rest. Pain occurs during exercise because the collaterals cannot provide the necessary increase of blood flow. The presence of significant trophic changes usually indicates further disease distal to the point of occlusion preventing the collaterals from functioning as well.

One can almost always, on the basis of clinical evaluation, determine if a patient is a candidate for resectional therapy. Specialized techniques are of interest, but add little in regard to choice of treatment. Arteriography is not a benign procedure, as thrombosis at the site of needle puncture and deaths from renal complications have been obtained. Its use should be limited to final evaluation of the remaining vascular tree when resectional therapy is considered on the basis of the clinical evaluation to be indicated.

J. Harold Harrison, M.D.



physician's bookshelf

BOOKS RECEIVED

Lyght, Charles E., M.D. (Editor), **THE MERCK MANUAL OF DIAGNOSIS AND THERAPY**, Ninth Edition, Merck and Company, Inc., Rahway, N. J., 1956.

Flippin, Harrison F., M.D., **GOEPP'S MEDICAL STATE BOARD QUESTIONS AND ANSWERS**, W. B. Saunders Company, Philadelphia, 1957, 569 pp., \$8.00.

Nesselrod, J. Peerman, M.D., **CLINICAL PROCTOLOGY**, Second Edition, W. B. Saunders Company, Philadelphia, 1957, 296 pp., \$7.00.

Cecil, Russell L., M.D., and Howard F. Conn, M.D. (Editors), **THE SPECIALTIES IN GENERAL PRACTICE**, Second Edition, W. B. Saunders Company, Philadelphia, 1957, 780 pp., \$16.00.

Sollman, Torald, M.D., **A MANUAL OF PHARMACOLOGY**, Eighth Edition, W. B. Saunders Company, 1,536 pp., \$20.00.

Luisada, Aldo A., M.D., **THE HEART BEAT, GRAPHIC METHODS IN THE STUDY OF THE CARDIAC PATIENT**, Paul B. Hoeber, Inc., New York, 1953, 508 pp., \$12.00.

Statland, Harry, M.D., **FLUID AND ELECTROLYTES IN PRACTICE**, Second Edition, J. B. Lippincott Company, Philadelphia, 1957, 200 pp., \$6.00.

Hampton, Oscar P., Jr., M.D., MC, USAR, Medical Department U. S. Army; Col. John B. Coates, Jr., MC, Editor-in-chief; Mather Cleveland, M.D., Editor for Orthopedic Surgery; and Elizabeth M. McFetridge, M.A., **ORTHOPEDIC SURGERY IN THE MEDITERRANEAN THEATER OF OPERATIONS**, Dept. of the Army, Washington, 341 pp.

Forkner, Claude E., M.D., **PRACTITIONERS CONFERENCES Held at The New York Hospital-Cornell Medical Center**, Appleton-Century-Crofts, Inc., New York, 1957, 315 pp., \$6.75.

Garland, Joseph, M.D., **THE PHYSICIAN AND HIS PRACTICE**, Little, Brown and Company, Boston, 1954, 257 pp., \$5.00.

Cleckley, Herve, M.D., **THE CARICATURE OF LOVE**, The Ronald Press Company, New York, 1957, 311 pp., \$6.50.

TRANSACTIONS OF THE AMERICAN OPHTHALMOLOGICAL SOCIETY, 1956, Columbia University Press, New York, 1957, 816 pp., \$18.00

REVIEWS

Conn, Howard F., M.D. (editor), **CURRENT THERAPY 1957, LATEST APPROVED METHODS OF TREATMENT FOR THE PRACTICING PHYSICIAN**, W. B. Saunders Company, Philadelphia, 1957, 731 pp., \$11.00.

This is the ninth volume in a series that began in 1949. These volumes contain useful, concise, and adequate information regarding the best known methods of treatment for the common conditions likely to be encountered by any physician practicing general medicine. Eight outstanding internists have served as consultants in the preparation of this volume, as well as outstand-

ing representatives of the fields of gynecology, obstetrics, urology, dermatology, syphilology, psychiatry, and neurology. Individual articles are each written by a physician who is connected in some way with a medical school or an outstanding teaching hospital. There are three hundred of these contributors, and in practically every instance the contributor is an individual who is recognized as an authority on the subject which he discusses. Thus, one has in this volume access to the best available knowledge and advice from the leading authorities on each subject one wishes to choose. Therefore, the volume is extremely valuable to the busy physician who does not have a library at his disposal or the necessary time in which to search for appropriate articles in medical journals. Because the book is published every year, it comes as close as such a volume can to being up to date.

There are some objections to this type of volume. As one who buys the volume every year, this reviewer feels that he is buying each time a lot of the same material that was contained in the volume published the previous year. The treatment for every disease does not change annually and there is still a lot of very good material in the volumes published several years ago. The publishers of loose-leaf volumes try to overcome this objection by sending out replacement pages from time to time but this proves a problem to the physician who cannot find time to remove the old pages and replace them with the new ones. Because the present volume is not expensive, the objection that much of the old material is contained in each new volume is a minor one.

This reviewer has found these volumes to be very useful and well worth the cost. It is his intention to continue to be a regular subscriber to the annual volume.

Arthur M. Knight, Jr., M.D.

Equen, Murdock, M.D., **MAGNETIC REMOVAL OF FOREIGN BODIES**, Charles C. Thomas, Publisher, Springfield, Illinois, 1957, 92 pp., \$4.50.

Instructive and fascinating describes the 94-page book "Magnetic Removal of Foreign Bodies" written by Dr. Murdock Equen (founder of Ponce de Leon Infirmary, Atlanta, Georgia) to describe "The Use of the Alnico Magnet in the Recovery of Foreign Bodies from the Air Passages, the Esophagus, Stomach, and Duodenum."

These few pages beautifully show by case histories and x-rays Dr. Equen's use of the Magnet in 228 cases without fatality over a 13-year period.

The book is written primarily for the Bronchoscopist; however, all doctors who have experiential contacts with those who have aspirated or swallowed foreign bodies will find this book a most valuable instruction. Dr. Equen writes in an informal conversational style easily comprehended by any of our profession. It is the first complete review of its kind on this subject.

Dr. Equen is to be commended for his research and studies resulting in the various modifications of the original Alnico Magnet and the auxiliary apparatus of his own design that he so successfully uses.

James M. Hicks, M.D.

Smith, Donald R., **GENERAL UROLOGY**, Lange Medical Publications, Los Altos, Calif., 1957, 328 pp.

Due to the cardboard binding, the average bibliophile may not include this book among his treasures; however, Dr. Smith has produced an extremely valuable

book for the medical student and medical practitioner at a moderate price and of reasonable length.

For a number of years the text books concerned with the genito-urinary tract have generally been written for the third-year medical student or for the individual devoting all of his time to the practice of genito-urinary tract surgery. In the first instance these efforts have been inadequate to prepare a student to reach an informed decision in regard to problems involving the genito-urinary tract. In the second instance the multivolume texts have been so detailed and extensive in their presentation of subject matter as to exclude them from general use. *General Urology* is a reasonable compromise between these extremes. The subject is concisely presented with excellent pertinent illustrations by Prof. Ralph Sweet.

The chapter on nonspecific infections of the urinary tract should be a valuable guide for anyone in the practice of medicine. After emphasizing the statement that "the stained smear of urinary sediment is *the most important step in urologic diagnosis*," the author quite correctly points out that "qualitative cultures must be avoided, because it is impossible to obtain a truly sterile urine specimen . . . Some type of quantitative estimation of the number of bacteria must be made, pour-plates and colony counts should be done . . ."

The chapter on the neurogenic bladder is no more confusing than other efforts to clarify this perplexing condition.

Samuel S. Ambrose, Jr., M.D.

Allen, J. Garrott, M.D.; Harkins, Henry N., M.D.; Moyer, Carl, M.D.; and Rhodes, Jonathan E., M.D., *SURGERY, PRINCIPLES AND PRACTICE*, J. P. Lippencott, Philadelphia, 1957, 1,495 pp.

This is a textbook of general surgery which is written by approximately thirty-two authors, each well qualified in his field. These authors present the art and science of surgery as it is now taught in the medical schools of this country, and it is presented under fifty different surgical headings. Starting with the philosophy of surgery, they have covered in detail and more thoroughly than the majority of textbooks the physiological, biochemical, pathological, and anatomical basis of surgical practice. Ophthalmology and oto-rhinolaryngology have been omitted; however, practically all other subjects of surgery have been covered.

This is a large volume, 1,495 pages, and one cannot help but wonder if it would not have been better in two volumes, as it is somewhat bulky and hard to handle.

This is definitely a textbook of surgery which is primarily written for medical students, as well as the man who has finished his formal training but wishes to remain a "student of medicine." It does not cover operative procedures or techniques to any marked degree. It covers well the diagnosis and preparation of the patient prior to the actual surgical procedure, and it includes anesthesia. The book is easy to read, and the charts and photographs are very well identified and very illustrative. More than one viewpoint is given, and clinical cases are presented.

Not only does it properly evaluate the preoperative diagnosis and findings, but it also is very illuminating concerning postoperative complications and such matters as fever headache, pain, gas therapy, urinary retention, oliguria, edema, nausea, vomiting, and the psychotic symptoms that go along with the surgical patient.

This book exemplifies the calibre of the authors in that they stress the practice of surgery and qualify a

good surgeon as being more than just a good technician. This book can certainly be recommended without reservation to anyone who does any surgery.

Milford B. Hatcher, M.D.

Zimmerman, Leo M., and Levine, Rachmiel, *PHYSIOLOGIC PRINCIPLES OF SURGERY*, W. B. Saunders Company, Philadelphia, 1957, 988 pp., \$15.00.

As a medical student, one of the most fascinating and interesting subjects for me was the study of physiology. To learn more about this science which treated the functions of the living organism and its parts did much to relieve the monotony of the long hours of anatomy and pathology. Best and Taylor's biblical-like, thick, red volume was much enjoyed. As I entered into a residency in surgery, the necessity for a better knowledge of the physiologic and chemical alterations in my patients occasioned by injury and disease became keenly apparent.

Leo Zimmerman, a professor of surgery, and Rachmiel Levine, a physiologist, have collaborated in editing and contributing a timely text composed of current physiological concepts. The authors are for the most part well known authorities in their fields. These include internists, surgeons, anesthesiologists, biochemists, pediatricians, hematologists, urologists, pathologists, orthopedists, obstetricians, gynecologists, and the entire gamut of our specialty groups. The book is most complete in its coverage insofar as all surgeons are concerned. It is introduced with a discussion of the metabolic changes associated with injury and a consideration of infections and antibiotics. It continues with chapters on radiation and thermal injuries, transplantation of tissues, hemorrhage and shock, blood transfusions and considerations of various types of parenteral therapy, chapters on anesthesia, heart disease, peripheral vascular disorders, the respiratory tract, the entire gastrointestinal tract, the liver, most of the endocrine glands, the kidneys and the male genital tract and the female internal genitalis, the breast and central nervous system. Some of the better known contributors are Pulaski, Cannon, Frank, Baffes, Sadove, Fell, Mackler, Sweet, and Cope.

These chapters have been written with an attempt to cull the more trivial facts and to consider the most practical aspects in the various organ systems and specialties represented. As was emphasized by the authors in their preface, this book has been an attempt to furnish the candidate for American Board Certification, the resident on the wards, and the surgeon in practice the information which he might desire concerning various physiological problems in surgery, and to do this between the covers of a single book. As they further emphasize it would be impossible for one person to be expected to have sufficiently broad knowledge to cover authoritatively all phases of surgery, and that in the time required for a single author to prepare a book of this type, the earlier material would have become obsolete before the latter were finished, so rapid in progress being made.

The book is well organized and certainly represents the work of active and busy doctors who are engaged in practice, research, teaching, and writing. The predominate appeal is certainly pointed to the various surgical specialists; however, I feel certain that all practicing physicians will have an occasion to use this for a ready reference in the multifaceted problems which may, and do, arise in the active practice of medicine.

Robert J. Hoagland, Col., MC



abstracts by georgia authors

Witham, A. Calhoun, Medical College of Georgia, Augusta, Ga. "Double Outlet Right Ventricle; A Partial Transposition Complex;" *Am. Heart J.* 53:928-939 (June) 1957.

Three anatomic variations of a partial transposition complex characterized by pulmonary and systemic arterial circuits arising entirely from the right ventricle are described. Clinical data is presented in the first, the "Eisenmenger type," in which the heart revealed coarctation and complete transposition of the aorta, large pulmonary artery in normal position, ventricular septal defect, and patent ductus arteriosus. The clinical picture of this syndrome is characterized by slowly developing cyanosis, a parasternal systolic murmur, occasionally a diastolic murmur and signs of aortic coarctation. Survival may reach the second decade. Fluoroscopy reveals plethoric lung fields, combined ventricular enlargement, and a wide supracardiac shadow in the anteroposterior and left oblique views. Another example of this category was complicated by absence of the aortic arch. It was associated with a small separate ascending aorta, absence of the aortic arch, and descending aorta supplied by a patent ductus. All vessels arose from the right ventricle. Survival past the age of six years has not been recorded in this type.

The second principal variation of the "double outlet" right ventricle is the Fallot type. It resembles the tetralogy of Fallot because of various degrees of pulmonary hypoplasia. Biventricular enlargement, however, suggests that one is not dealing with a true tetralogy, and angiocardigraphy may demonstrate the exact relationship of the septal defect to aortic and pulmonary orifices.

Boyd, M. L., 563 Capitol Ave., S.W., Atlanta, Ga. "Transplantation of the Ureter into the Bladder;" *J.A.M.A.* 164:651-654 (June 8) 1957.

Of five patients having had ureteral transplantation into the bladder, three had long periods of freedom from upper urinary tract injury after the operation. Two cases demonstrate that, even when the lower part of the ureter is freed from adhesions and the remaining ureter is shorter than is desirable, good results are possible. Such good results in cases of tumors of the bladder make it appear desirable to perform resection of the bladder with transplantation of the ureter into the bladder rather than transplantation of the ureter into the colon. Transplantation of the ureter into the bladder is also frequently the solution of the problem

arising from operative ureteral injury in pelvic surgery. Where transplantation is feasible, it is better than end-to-end anastomosis of the ureter, or some less satisfactory method, or than a more radical procedure such as nephrectomy.

Perkinson, Neil G., 384 Peachtree St., N.E., Atlanta, Ga. "Melanoma Arising in a Cafe au Lait Spot of Neurofibromatosis;" *Am. J. Surg.* 93:1018-1020 (June) 1957.

This is the first case of this type reported in the medical literature. The author emphasizes the frequency of "junctional change" in cafe au lait spots, that change making that individual cafe au lait spot in reality a junctional nevus, the precursor of malignant melanoma.

Harrison, J. Harold, M.D., 69 Butler St., S.E., Atlanta, Ga. "Ivalon Sponge (Polyvinyl Alcohol) as a Blood Vessel Substitute (Failure in Experimental Animals);" *Surgery* 41:729 (May) 1957.

Polyvinyl sponge, theoretically, has several advantages as a vascular prosthesis. It can be molded into any shape making a variety of branches possible, and after molding the graft is elastic and has the consistency of a blood vessel making it technically easier to insert. This paper was a report of the results obtained in 25 dogs with molded grafts of Ivalon sponge replacing large and small arteries.

Two of nine animals with grafts in their thoracic aortas exsanguinated at 73 and 98 days from aneurysm and rupture of the grafts. All the remaining developed fusiform dilatation of the grafts that progressed during the six months observation period. There was a fusiform aneurysm in one and a dissecting aneurysm in another of the grafts replacing the abdominal aorta.

The sponge rapidly became hard and brittle losing all its elasticity. It underwent degeneration after implantation in the body and was replaced by fibrous tissue. The latter is not adequate to prevent aneurysm and rupture of a graft particularly replacing large vessels as evidenced by failure in these animals.

The advantages that Ivalon sponge possesses as an artery substitute are outweighed by its disadvantages. Because of its chemical instability leading to breakdown with aneurysm and rupture it is felt to be unsatisfactory for the replacement of blood vessels.

Juni, Elliot, and Heym, Gloria A., School of Medicine, Emory University, Atlanta, Ga. "Preparation Properties and Colorimetric Determination of Diacetylmethylcarbinol;" *Archives of Biochemistry and Biophysics* 67:410-422 (April) 1957.

A common characteristic of all diphosphothiamine enzymes is their ability to carry out condensation reactions yielding acyloins such as acetylmethylcarbinol. Studies concerned with the bacterial dissimilation of 2, 3-butanediol have revealed a new cyclic pathway for the oxidation of this compound. Diacetyl is an intermediate of this cycle and is activated by a diphosphothiamine enzyme which catalyzes an acyloin condensation reaction yielding diacetylmethylcarbinol (3-methyl-3-hydroxy-2, 4-pentane-dione) and acetic acid.

Methods for the enzymic and chemical synthesis of substrate amounts of diacetylmethylcarbinol have been outlined. Diacetylmethylcarbinol has been characterized chemically and some of its properties studied. A colorimetric procedure for the quantitative determination of diacetylmethylcarbinol has been described.

Hoagland, Robert J., Col., MC, Fort Benning, Ga., and Henson, Henry M., M.D. (Deceased), **SPLenic RUPTURE IN INFECTIOUS MONONUCLEOSIS**; *Annals of Int. Med.* (June) 1957.

A review of published cases of splenic rupture in mononucleosis indicated that the diagnosis was often made too late to be of help to the patient. An important cause of delay is the perpetuation of the erroneous concept of mononucleosis as a "protean disease." The clinical manifestations of mononucleosis are relatively constant unless complications occur. If abdominal pain of moderate or severe intensity occurs in a patient known to have mononucleosis, splenic rupture should be suspected and repeated examinations and blood counts should be done to confirm the suspicion. Left shoulder pain may be present; this often can be brought out by raising the foot of the bed.

Sooner or later, muscle spasm and rigidity will be evident. An increase in pulse rate strengthens the probability of splenic rupture, and a falling hematocrit clinches the diagnosis.

If a patient with mononucleosis goes into shock, even without abdominal pain, splenic rupture may be the cause. Prompt operation may be life-saving; therefore, it may be wise to operate even if the blood count has not yet definitely reflected hemorrhage—if all other aspects of the case point to splenic rupture.

Harrison, J. Harold, M.D., 69 Butler St., S.E., Atlanta, Ga. "A Teflon Weave for Replacing Tissue Defects;" *Surgery, Gynecology and Obst.* 104:584 (May) 1957.

The good results with "Teflon" as a vascular prosthesis prompted a study of its use for the replacement of other tissue defects. An open and a close weave were inserted in clean and infected wounds in the abdominal wall, chest wall, and diaphragm in 41 dogs, using tantalum wire gauze as a control.

There was good healing with all the materials in the clean wounds. The experimental results indicated that an open weave of "Teflon" is superior to tantalum as it is more pliable and will maintain its strength over a longer period of time. Its clinical usage should be successful in the replacement of defects in the abdominal wall and diaphragm where these qualities are desirable.

The weave must have a porosity similar to that of tantalum wire gauze, particularly if there is any chance of wound infection. A close weave prevents adequate drainage and the ingrowth of fibrous tissue with isolation of its individual fibers which are necessary for healing an infected wound.

The method of preparation, technique of insertion and limitations to the Teflon weave were discussed.

Madison, William M., Jr., and Logue, Bruce, Emory University School of Medicine, Atlanta, Ga. "Isolated ('Primary') Chylopericardium;" *Am. J. Med.* 22:825-830 (May) 1957.

The second case of a rare entity, isolated or primary chylopericardium, was discovered in a 40-year-old white female. Cardiomegaly had been apparent for seven years and symptoms consisted only of mild exertional dyspnea and substernal "heaviness" in the supine position. When pericardial effusion was suggested by angiocardigraphy, pericardial aspiration revealed the presence of milky white fluid having the appearance of

chyle. Following the oral administration of a lipophilic dye and its recovery from the pericardial fluid, an anatomic communication between the thoracic duct and the pericardial space was demonstrated; but at subsequent operation no direct communication was identified. Ligation and excision of both major lymphatic channels and all collaterals low in the thorax together with the establishment of a pericardial window for drainage resulted in an apparent cure, with no recurrence of the effusion. The original case was found to be the result of a superior mediastinal hygroma (lymphangiomatous hamartoma), but the etiology of the chylous pericardial effusion in the present case is unknown.

Harrison, J. Harold, M.D., 69 Butler St., S.E., Atlanta, Ga. "Limitations to Knitted Synthetic Tubes as a Vascular Prosthesis;" *A.M.A. Arch. Surg.* 74:557 (April) 1957.

One of the commonly reported disadvantages of synthetic prostheses is the lack of elasticity. To overcome this, knitting of the tubes was advocated, and good results were reported with knitted tubes of Orlon. This report was prompted by the equivocal results obtained in 24 dogs with knitted tubes of Orlon.

The reported advantages of elasticity of the walls of the grafts was not observed at the time of insertion or sacrifice.

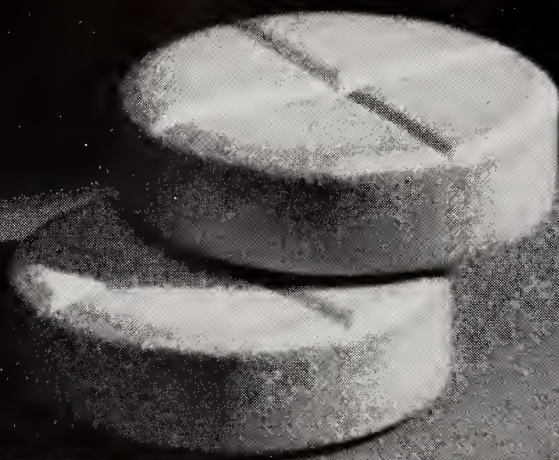
The Orlon tubes, knitted as closely as possible were too porous. This allowed excessive bleeding through the interstices of the graft, resulting in exsanguination or hematomas. The porosity can be reduced by shrinkage on a mandril at elevated temperature to a sufficient degree to prevent bleeding. This is accompanied by an increase in thickness and rigidity of the walls of the graft. Such prostheses are satisfactory for the replacement of segments of large vessels, but functional elasticity should not be expected. They are unsatisfactory for replacing vessels less than nine mm. in diameter, as the thickness and rigidity of the walls will cause the grafts to function more independently of the intra-arterial pressure resulting in a high rate of thrombosis from buckling.



The reasons for these conclusions were discussed.

Thoroughman, J. C., 5998 Peachtree Road, N.E., Atlanta, Ga. "Appendicitis—A Clinical Study;" *South. M. J.* 50:683-686 (May) 1957.

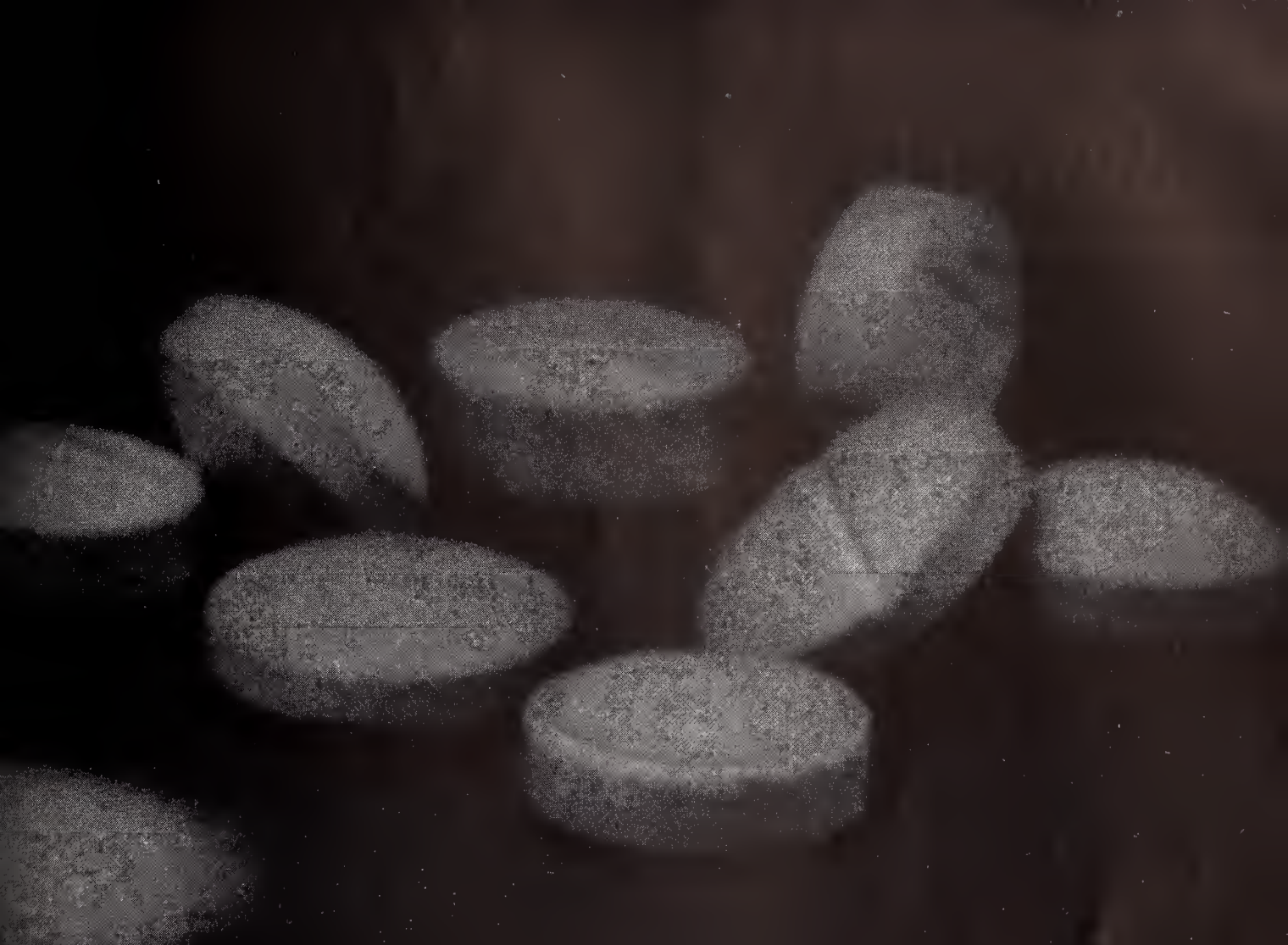
There is no generally accepted permissible diagnostic error for acute appendicitis. The error reported in several series was 13, 34, 30, 35, 60 per cent and in the present series was 25 per cent. There was one mortality in 644 operations in this series in which an appendectomy was performed with a preoperative diagnosis of acute appendicitis. Mild or moderate complications occurred in 10 per cent of patients in whom a normal appendix was found. The diseases responsible for the incorrect diagnoses in these patients are tabulated, and the importance of seminal vesiculitis as a mimic of acute appendicitis is discussed. The incidence and importance of various aspects of the history, physical findings, and laboratory tests commonly used in the diagnosis of acute appendicitis are presented. A diagnostic error of from 15-20 per cent is suggested as an acceptable figure for good surgical practice.

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(1) Boger, W. P.; Strickland, C. S. and Gylfe, J. M.: *Antibiot. Med. & Clin. Ther.* 3:378 (Nov.) 1956.

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abstracts

CONTINUED

Juniper, Kerrisan Jr, and Bursan, E. Napier Jr., 1083 W. Peachtree St., Atlanta 9, Ga. "Biliary Tract Studies; the Significance of Biliary Crystals;" *Gastroenterology* 32:175-211 (February) 1957.

Duodenal drainage bile obtained by intubation of 246 patients was studied microscopically to determine the clinical significance of biliary crystals. The group studied consisted primarily of patients suspected of having pancreatic, hepatic, or biliary tract disease. Duodenal drainage findings were compared with results of cholecystograms, liver and pancreatic function tests, microscopic examination of bile removed from gallbladders and common ducts at operation, microscopic and x-ray diffraction analysis of gallstones, and pathologic findings at operation or autopsy.

The findings indicate that cholesterol crystals, calcium bilirubinate granules and mixed crystals (known as microspheroliths), either singly or in combination, are of clinical significance but do not necessarily signify the presence of a primary calculous disease. Significant numbers of these formed elements were found in the following primary conditions as indicated:

1. Cholelithiasis and/or cholecystitis—54 of 88 cases.
2. Pancreatitis (no gallstones) 6 of 20 cases.
3. Non-malignant liver disease—9 of 33 cases.
4. Carcinoma of the pancreas, liver, biliary tract—5 of 16 cases.
5. Chronic hemolytic anemia (no gallstones) 2 of 2 cases.
6. Suspected upper gastrointestinal disease but with normal laboratory and x-ray studies—9 of 30 cases.
7. Normals—1 of 58 cases.

Microspheroliths showed considerable correlation with chronic hemolytic anemia or calcium carbonate-containing gallstones.

Duodenal drainage is of limited value as a clinical test for cholelithiasis because biliary crystals may occur in non-calculous pancreatic, hepato-biliary and hemolytic disease. Only in a small percentage of cases is this test of clinical aid in diagnosis.

Peacock, Lamar B., and Davison, Hal M., 478 Peachtree St., N.E., Atlanta, Ga. "Observations on Iodide Sensitivity;" *Ann. Allergy* 15:158-164 (March-April) 1957.

Five hundred and two cases of bronchial asthma were studied to evaluate the number and types of reactions to the administration of potassium iodide in treatment. Sixteen-and-one-tenth per cent had sufficient reactions to warrant discontinuance or sharp reduction of their medication. These reactions were physiologic ones from over-dosage or similar symptoms occurring at lower dosage due to over-reactivity on the part of the individual. None of these patients developed signs or symptoms of true hypersensitivity such as arteritis, marked eosinophilia, proteinuria, jaundice, polyneuritis

or bullous iododerma. No cases of definite myxedema were noted. Of 29 patients reacting to inorganic iodides, 24 were able to get good relief from asthmatic symptoms without reactions, when placed on an organic iodine solution.

Rumble, Lester, Jr.; Cooper, Manuel N.; Bickers, Donald S.; Shellack, John K.; Waits, Edward J.; and Hyatt, Kenneth; 177 Rumson Rd., N.E., Atlanta, Ga. "Observations During Apnea in Conscious Human Subjects;" *Anesthesiology* 18:419-438 (May-June) 1957.

This article is the report of observations made on ten conscious volunteer human subjects under controlled ventilation. Apnea was produced with a drip of Succinylcholine (Anectine), and during a period of ventilation with 100 per cent oxygen, measurements were taken of intracardiac pressures, pressures within the anesthetic circuit, arterial oxygen and carbon dioxide saturation, blood pressure, pulse, and EKG tracings, along with a continuous electro-encephalographic tracing.

Subsequent to these determinations, these subjects were anesthetized in exactly the same manner as has been carried out in over 15,000 clinical cases, and the determinations repeated. Subsequent to the repetition of the values for oxygen and carbon dioxide, each patient was subject to a short period of hypoxia in order to ascertain the changes manifested by this state.

The results obtained from these observations show that there is little change induced by controlled respiration when carried out in this fashion. The minor changes that did occur in intracardiac, particularly intra-atrial pressures, were well compensated for both in the conscious and unconscious state. It is the opinion of the authors that this method of handling an unconscious patient brings about the least change in normal physiology that is possible during the performance of anesthesia and surgery.

Wenger, Julius; Kirsner, Joseph B.; and Palmer, Walter L.; School of Medicine, Emory University, Atlanta, Ga. "Blood Carotene in Steatorrhea and the Malabsorption Syndrome;" *Am. J. Med.* 22: 373-380 (March) 1957.

Carotene, or pro-vitamin A, is a normal constituent of the diet found primarily in green and yellow vegetables; the presence of carotene in blood plasma or serum depends entirely upon dietary intake and a normal absorptive mechanism. In 110 patients without organic gastrointestinal disease, the average plasma carotene level was 123 mcg. per 100 ml.; 94 per cent of the determinations fell between 70 and 300 mcg. Those few patients who had a low blood carotene level due to a poor diet showed a rise to normal after receiving a large oral dose, while patients with malabsorptive syndromes such as sprue, pancreatic insufficiency, advanced regional enteritis, the post-gastrectomy syndrome, etc., retained low levels of blood carotene.

This method was compared with quantitative fecal fat determinations and fat balance studies in 30 patients with malabsorption, and the conclusion was that a low level was a reliable test as a screening method for steatorrhea in all but the mildest cases. These patients had blood carotene levels ranging from 0 to 29 mcg. (severe depletion), and 30 to 69 mcg. (moderate depletion). With proper treatment of the underlying disease, the blood carotene levels rose, thus affording a simple means of judging the effect of therapy.

IMPORTANCE OF THE GENERAL EXAMINATION OF THE CARDIAC

L. MINOR BLACKFORD, M.D., Atlanta, Ga.



THE MAN WHO BEGINS the examination of a patient by slapping his stethoscope over the apex of the heart betrays that he knows little about the heart. The first thing he should do is to look the patient over. Is he pale? If his hemoglobin is less than eight grams, the least exertion may exhaust him, but he can probably sleep without a pillow. Or is he plethoric? Is cyanosis or clubbing present?

Is he very fat? Carrying even 30 pounds of excess lard around will eventually tire anybody, and some people carry four times that much. Or has he lost weight rapidly? Is the thyroid enlarged or nodular? Does he have a stare or tremor?

Are varicose veins responsible for swelling of his legs? Or tight garters? Is there tenderness along the right costal margin? Is the liver enlarged? Is the liver edge smooth? Do large veins converge on the navel? Is there fluid in his belly? Can you palpate a mass in the lower abdomen that arises from the pelvis? Is the spleen palpable? Can you find any large, hard lymphnodes?

In the conjunctivae or retinae can you pick up the tiny hemorrhagic emboli characteristic of subacute bacterial endocarditis? Are the sclerae lemon-colored or bile-stained? Funduscopic examination is of greater value in determining the severity of hypertension than a single blood pressure determination. Are the pupils normal? Are the knee jerks present, equal, and active?

Is he a barrel-chested man? Is the thorax hyperresonant? Is expiration prolonged? Is it accompanied by expiratory wheezes? Sometimes such wheezes causing respiratory distress result from excessive use of tobacco: if so, this distress will improve if you can get your patient to give up cigarettes for three weeks. Are the breath sounds the same on both sides? Is moisture present in the right base? Or fluid?

Many patients come in complaining of a murmur or "a leaking heart." If the murmur was detected

under the age of four, the chances favor congenital heart disease. One should also cross-examine the patient—or his parents—as to possible rheumatic fever in the past, but the absence of such a history does not rule out rheumatic valvular disease. On the other hand, a history may be misleading: a very robust college senior of 22 with a patent ductus recently tried to make me believe that in four years of routine examinations no physician had ever noted anything wrong with his heart!

In school children at least eight out of 10 murmurs picked up on routine examination will prove of no importance. In one of the 10 further study and observation will be required, and only in the tenth will definite disease be found. The presence of a murmur is *not* an indication for digitalis.

While the importance of taking the blood pressure has been exaggerated, it should always be done. If it is high in a robust young person, it is well to see if his femoral arteries pulsate. If they do not, try the abdominal aorta and look for pulsating collateral vessels. I saw two coarctations in the Army, one in a veteran of the Battle of the Bulge.

Examination of the blood and urine should always be done. An x-ray of the chest or fluoroscopic examination is desirable.

The question of an electrocardiogram arises in almost every case of heart disease, organic or otherwise. If the patient is greatly concerned about his heart, although perfectly sound infratentorially, a tracing is always indicated for his peace of mind. (If the explanation of easy tiring, however, is attributed to acute leukemia or a bleeding fibroid, an electrocardiogram is hardly necessary.) There is much to be said for routine yearly electrocardiograms on persons over 40.

Tracings are useful in the management of active rheumatic fever and coronary disease. In these conditions serial tracings are vastly more important

Continued on Next Page

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

EXAMINATION OF CARDIAC / Blackford

than single ones. The first one taken on a rheumatic young person may appear well within the limits of normal until compared with one taken several months after recovery. Similarly, a cardiogram on a man of 60 which appears alarming, may be unchanged after 15 more years of productive life.

Finally, if Dr. White may be quoted again, trifling normal variations in the electrocardiogram are much oftener misinterpreted as of importance than are significant changes overlooked.

Remember two things: other pathologic conditions may simulate disease of the heart, but heart disease does not exclude other troubles.

104 Ponce de Leon Ave., N.E.

The Month In Washington

Washington, D. C.—The economy drive to the contrary notwithstanding, health spending by the Department of Health, Education, and Welfare for the fiscal year that began this July already is assured of surpassing last year's record by some \$33 million. This assumes, of course, that no further requests will be made by HEW for supplemental funds, a practice common in government for many years.

Research programs were the most favored by legislators, many of whom spoke out against federal spending by other agencies. But when the health budget came up for debate, the economy oratory subsided.

In only one instance was a health program cut back and to the surprise of many, it occurred in the Senate which traditionally restores budget cuts originating in the House. A sum of \$45 million was voted, instead of the House-approved \$50 million, for grants to states for sewage treatment works construction; but then the Senate wrote in language permitting states to get their maximum allotments a full year after the fiscal year ends.

The Hill-Burton hospital construction program received \$3.8 million less than last year but only because the administration asked for \$121.2 million instead of the \$125 million appropriated last year.

The National Cancer Institute received the largest dollar increase of any health item in the budget. The increment was \$8 million over last year. The administration had asked for \$48.4 million, the House voted \$46.9 million, and the Senate raised this to \$58.5. It was finally compromised at \$56.4 million.

Congress obviously agreed with the views expressed by the Senate Appropriations Committee: "... the committee is fully aware that it is providing funds for cancer research, the outcome of which is unknown. On the judgment of those who are scientifically most competent, the committee is fully willing to risk the investment on the ground that the chance of a big payoff is a reasonable one. Such risks are inherent in research."

The Institute of Arthritis and Metabolic Diseases fared well, too, getting a total of \$20,385,000 compared with last year's \$17,885,000. And the Senate Committee charged the institute with taking leader-

ship in research on effects of radiation on the human organism.

The Mental Health Institute's spending has been going steadily upward, and this year it was given another boost with a final appropriation of \$39,217,000, an increase of about \$4 million. Other research totals for the current year: National Heart Institute, \$3,936,000; Neurology and Blindness Institute, \$21,387,000; Allergy and Infectious Disease Institute, \$17,400,000.

On only one score did the research advocates lose out. The House view prevailed in conference on the setting of a 15 per cent ceiling on additional overhead costs allowed schools and other institutions getting federal grants. This question which drew considerable attention in hearings is likely to be reopened. Congress wants a General Accounting Office study by the end of this year.

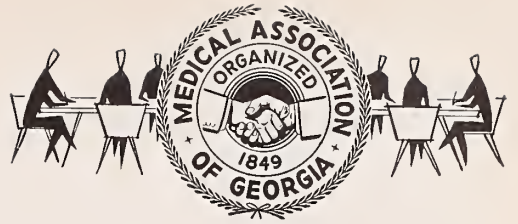
In voting a \$5 million increase (to \$22,592,000) for general public health assistance to the states, Congress was reaffirming its support of helping local health departments increase their professional staffs and broaden their services. The Senate Committee report contained this significant language:

"... with a population increase of more than 20 million during the past decade, there are no more organized health departments than there were 10 years ago. This means that 18 million people are living in areas with no full-time organized community health services, and millions more live in areas where such services are only fragmentary."

A few days later, the Public Health Service announced plans for a broad survey of rural health needs, particularly in sparsely settled areas. It picked for its first study Kit Carson County, Colo., an area known for its scattered farm population, low income level and adverse climatic conditions.

CAPITAL NOTES:

The President has signed into law a two-year revision of the doctor draft law permitting selective call-up of physicians to age 35 if they were deferred from regular draft service to complete professional training. . . . The poliomyelitis vaccine act expired July 1 with all but \$400,000 of \$53.6 million taken up by states for inoculation programs.



1957-58

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W. L. Pomeroy, Waycross

Medical School Courses

Chris J. McLoughlin, Atlanta, *Chairman*
J. Lee Walker, Clarkesville
Rafe Banks, Gainesville

Social Security Tellers Committee

D. Lloyd Wood, Dalton, *Chairman*
A. W. Simpson, Jr., Washington
Ralph W. Fowler, Marietta

Distinguished Service Award

David Henry Poer, Atlanta, *Chairman*
C. F. Holton, Savannah
Ralph H. Chaney, Augusta

Delegates to the AMA

Delegate—C. H. Richardson, Sr., Macon (1959)
Alternate—J. W. Chambers, LaGrange (1959)
Delegate—Eustace A. Allen, Atlanta (1958)
Alternate—Wm. R. Dancy, Savannah (1958)
Delegate—Spencer Kirkland, Atlanta (1958)
Alternate—Henry H. Tift, Macon (1950)

STANDING COMMITTEES

Cancer Committee

Hoke Wammock, Augusta, *Chairman*
J. E. Scarborough, Emory University
David Henry Poer, Atlanta
R. C. Pendergrass, Americus
Enoch Callaway, LaGrange
W. F. Jenkins, Columbus
John L. Barner, Athens
F. G. Eldridge, Valdosta
Lester Harbin, Rome
Everett L. Bishop, Atlanta
Thomas Harrold, Macon
Lee Howard, Sr., Savannah
Neal F. Yeomans, Waycross
Julian B. Neel, Thomasville
Major F. Fowler, Atlanta
Wadley R. Glenn, Atlanta
John T. Mauldin, Atlanta

Constitution & By-Laws

Thomas W. Goodwin, Augusta, *Chairman*
William P. Harbin, Rome
Eustace A. Allen, Atlanta

Geriatrics

Edgar Woody, Jr., Atlanta, *Chairman*
Peter L. Scardino, Savannah
Milton F. Bryant, Atlanta

History & Vital Statistics

J. Calvin Weaver, Atlanta, *Chairman*
Hoke Wammock, Augusta
R. H. McDonald, Newnan
Edgar Woody, Jr., Atlanta
C. Purcell Roberts, Atlanta

Hospital Relations

David Henry Poer, Atlanta, *Chairman*
Kirk Shepard, Thomasville
Robert B. Martin, Cuthbert
Herbert D. Tyler, Thomaston
H. A. Goodwin, Summerville
James R. Paulk, Moultrie
Rafe Banks, Gainesville
A. W. Simpson, Jr., Washington
Walter Brown, Savannah

Industrial Health

Robert M. Harbin, Rome, *Chairman*
Joe M. Bosworth, Atlanta
T. A. Peterson, Savannah
Allen M. Collinsworth, Atlanta
J. H. Crowdis, Blakely

Crawford W. Long Memorial

Lester Rumble, Jr., Atlanta, *Chairman*
Perry P. Volpito, Augusta
A. B. Boyd, Athens

Insurance & Economics

David R. Thomas, Jr., Augusta, *Chairman*
1st—John L. Elliott, Savannah
2nd—Rudolph F. Bell, Thomasville
3rd—Luther H. Wolff, Columbus
4th—Thomas E. Floyd, Griffin
5th—Charles S. Jones, Atlanta
6th—Herbert M. Olrick, Macon
7th—E. S. Marks, Marietta
8th—W. L. Pomeroy, Waycross
9th—W. Perrin Nicolson, III, Gainesville
10th—David R. Thomas, Jr., Augusta

Maternal & Infant Welfare

Charles M. Mulherin, Augusta, *Chairman*
Hugh J. Bickerstaff, Columbus
Eugene L. Griffin, Atlanta
Thomas C. McPherson, Atlanta
Helen W. Bellhouse, Atlanta
James W. Bennett, Augusta
Peter Hydrick, College Park
George H. Alexander, Forsyth

Medical Defense

Charles S. Jones, Atlanta, *Chairman*
W. Bruce Schaefer, Toccoa
Lee Howard, Sr., Savannah
Chris J. McLoughlin, Atlanta
J. G. McDaniel, Atlanta

Medical Education

Thomas L. Ross, Jr., Macon, *Chairman*
Charles F. Stone, Atlanta
R. C. McGahee, Augusta
Harry B. O'Rear, Augusta, *ex-officio*
Arthur P. Richardson, Atlanta, *ex-officio*

Legislation

J. Frank Walker, Atlanta, *Chairman*
Eustace A. Allen, Atlanta, *Vice-Chairman*
M. F. Simmons, Decatur
Albert M. Deal, Statesboro
Virgil Williams, Griffin

Professional Conduct

W. F. Reavis, Waycross, *Chairman*
C. F. Holton, Savannah
Wm. P. Harbin, Jr., Rome
H. Dawson Allen, Jr., Milledgeville
Hal M. Davison, Atlanta

Veterans' Affairs

Hartwell Joiner, Gainesville, *Chairman* (1958)
Charles R. Andrews, Canton (1959)
Lee Howard, Jr., Savannah (1960)

Woman's Auxiliary

Virgil Williams, Griffin, *Chairman*
Walker Curtis, College Park
Hal M. Davison, Atlanta
John L. Elliott, Savannah
W. G. Elliott, Cuthbert
W. B. Schaefer, Toccoa
Lee Howard, Sr., Savannah

Public Health

Hugh J. Bickerstaff, Columbus, *Chairman*
John Venable, Atlanta
Hoke Wammock, Augusta
Thomas W. Goodwin, Augusta
Edgar Woody, Jr., Atlanta
J. Calvin Weaver, Atlanta
David Henry Poer, Atlanta
Robert M. Harbin, Rome
David R. Thomas, Jr., Augusta
J. Frank Walker, Atlanta
Lester Rumble, Jr., Atlanta
Charles M. Mulherin, Augusta
Charles S. Jones, Atlanta
Thomas L. Ross, Jr., Macon
Rives Chalmers, Atlanta
W. F. Reavis, Waycross
John P. Heard, Decatur
J. Lee Walker, Clarkesville
Ted F. Leigh, Emory University
Hartwell Joiner, Gainesville
Edgar M. Dunstan, Atlanta

Public Service

John P. Heard, Decatur, *Chairman*
E. P. Inglis, Marietta
Albert M. Boozer, Dalton
E. C. McMillan, Macon
Peter L. Scardino, Savannah
A. H. Letton, Atlanta
Clarence C. Butler, Columbus
Thomas E. DuPree, Bainbridge
M. B. Sells, Jr., Augusta

Rural Health

J. Lee Walker, Clarkesville, *Chairman*
1st—Charles T. Brown, Guyton
2nd—Henry A. Bridges, Bainbridge
3rd—M. F. Arnold, Hawkinsville
4th—T. A. Sappington, Thomaston
5th—John P. Heard, Decatur
6th—H. R. Cary, Milledgeville
7th—H. C. Derrick, Lafayette
8th—Sage Harper, Douglas
9th—J. Lee Walker, Clarkesville
10th—Hugh B. Cason, Warrenton

Scientific Exhibit Awards

Ted F. Leigh, Emory University, *Chairman*
(1960)
Hoke Wammock, Augusta (1959)
Charles H. Richardson, Jr., Macon (1958)

Mental Health

Rives Chalmers, Atlanta, *Chairman*
J. R. Shannon Mays, Macon
Robt. J. Van de Wetering, Atlanta
Arthur M. Knight, Jr., Waycross
Paul T. Scoggins, Commerce
Albert J. Kelley, Savannah
T. J. Vansant, Jr., Marietta
Richard E. Felder, Atlanta
H. E. Valentine, Jr., Gainesville
T. G. Peacock, Milledgeville, *Consultant*
Guy V. Rice, Atlanta, *Consultant*

SPECIAL COMMITTEES

Blood Banks

Lester Forbes, Atlanta, *Chairman*
Lee Howard, Jr., Savannah
Walter L. Shepeard, Augusta
Hamil Murray, Gainesville
F. H. Thompson, Albany
Frank Lewis Beckel, Columbus

Crippled Children

J. C. Hughston, Columbus, *Chairman*
F. James Funk, Jr., Atlanta
John L. Chandler, Jr., Augusta
H. W. Muecke, Waycross
Robert A. Sears, Atlanta
J. W. Bennett, Augusta
W. G. Elliott, Cuthbert
W. U. Clary, Savannah
Fred E. Murphy, Jr., Thomasville
Charles E. Irwin, Atlanta

Medical Civil Preparedness

Edgar M. Dunstan, Atlanta, *Chairman*
Lee Battle, Rome
Perry P. Volpito, Augusta
J. Fletcher Hanson, Macon
T. J. Ferrell, Waycross
Joseph S. Skobba, Atlanta
Charles E. Dowman, Atlanta
Georgia M. Hutto, Columbus
John L. Elliott, Savannah

Lectureship

David Henry Poer, Atlanta, *Chairman*
Murdoch Eguen, Atlanta
Glenville Giddings, Sr., Atlanta
Floyd McRae, Atlanta

Charles Lamb, Albany
Enoch Callaway, LaGrange
C. H. Richardson, Sr., Macon
Grady N. Coker, Canton
Thomas W. Goodwin, Augusta
Henry Finch, Atlanta, *Member-at-Large*

Ministerial Liaison

Needham B. Bateman, Atlanta, *Chairman*
Avery M. Dimmock, Atlanta
Marion A. Hubert, Athens
Edward Y. Walker, Milledgeville
F. G. Eldridge, Valdosta

Eyecare of the Newborn

J. Jack Stokes, Atlanta, *Chairman*
Thomas C. McPherson, Atlanta
Joseph L. Girardeau, Atlanta
C. A. N. Rankine, Atlanta

Physician-Lawyer Liaison

Hal M. Davison, Atlanta, *Chairman*
W. Bruce Schaefer, Toccoa
Charles S. Jones, Atlanta
W. L. Pomeroy, Waycross
A. B. Conger, Columbus
Mr. John A. Dunaway, *ex-officio*
Robert Gottschalk, Savannah

American Medical Education Foundation

George T. Nicholson, Cornelia, *Chairman*
J. Hubert Milford, Hartwell
Ruskin King, Savannah
H. Ansley Seaman, Waycross
W. E. Storey, Columbus
John Ridley, Atlanta

STATE BOARDS

State Board of Medical Examiners

Glenville Giddings, Atlanta, *President*
R. H. McDonald, Newnan, *President-Elect*
Grady N. Coker, Canton
Fred J. Coleman, Dublin
Albert M. Deal, Statesboro (1959)
Q. A. Mulkey, Millen
J. W. Palmer, Ailey (1958)
Alex B. Russell, Winder (1958)
Charles K. Wall, Thomasville (1959)
L. W. Willis, Bainbridge (1959)

INSURANCE AND ECONOMICS COMMITTEE

CHAIRMAN DAVID R. THOMAS, JR., Augusta, called the meeting to order at 2:20 p.m. in the Pine Room of the Dempsey Hotel, Macon, June 15, 1957.

Members of the Insurance and Economics Committee present included David R. Thomas, Jr., Augusta, Chairman; John L. Elliott, Savannah, 1st District; Rudolph Bell, Thomasville, 2nd District; Luther H. Wolff, Columbus, 3rd District; Thomas E. Floyd, Griffin, 4th District; Charles S. Jones, Atlanta, 5th District, Co-Chairman; Herbert M. Olnick, Macon, 6th District; W. L. Pomeroy, Waycross, 8th District. Also present was Mr. M. D. Krueger, MAG Executive Secretary, Atlanta.

The Minutes of the November 18, 1956, meeting were reviewed.

Social Security—Members of the committee discussed Social Security (OASI Title II) for physicians. MAG House of Delegates action (1957), requesting a poll on this subject, and 1957 AMA House of Delegates action against this type of coverage for physicians were reviewed.

Catastrophic Hospitalization Insurance—Chairman Thomas called on Mr. Lafayette Davis of the Provident Life and Accident Insurance Company to explain a proposed plan of Catastrophic Hospitalization Insurance for members of the Association. The following changes in the policy were suggested by members of the committee:

(1) Raising the age for dependents to 21 and asking that "dependents may be carried to their 24th birthday if attending an educational institution and are dependent on member for more than 50 per cent of their support."

(2) Definition of nurse to read: "Registered graduate nurse or licensed practical nurse."

(3) Provide for nursing care at home as well as in the hospital.

(4) Emphasize that the plan to be put in force only after 60 per cent of the eligible members sign up, with no health questions or other usual medical restrictions. It was further suggested that MAG membership be the

key to eligibility.

(5) The question of "active practice" was raised, and it was moved that the policy be modified on this point to allow: That after policy holder has had policy in force for 10 years of active practice, his policy be continued to the age limit specified regardless of whether or not he is in active practice, and further that this modification be sought, if possible, and that the chairman and co-chairman be empowered to act to the best of their judgment on the matter. This motion was approved.

(6) Suggested deletion of the word "full" in referring to "active practice" so that it would read "active practice."

(7) The age limit of 70 as specified in the policy was discussed, and it was recommended that Mr. Davis inquire about an option for coverage from 70 to 75 or from 70 to 80 as a rider and not a part of the policy, to be sold on an individual basis.

It was moved and voted that this plan be approved pending clarification, with the chairman and co-chairman authorized to activate the plan for the Association after said clarification. The motion further endorsed a letter prepared by Mr. Davis to be signed by the president to be sent to all MAG members with an MAG return envelope and also approved an introduction card for personal solicitation bearing the Association's name.

Revised Georgia Plan—After a general discussion of some problems of the Revised Georgia Plan sponsored by the Medical Association of Georgia, two difficulties were noted: (1) the seeming lack of cooperation of MAG members in becoming participating physicians in the Georgia Plan; (2) certain difficulties encountered in the Georgia Insurance Commissioner's office in the wording of the Georgia Plan.

It was moved and voted that a full meeting of the Insurance and Economics Committee, with the Health Insurance Council, be held early in the fall for a complete review of the Georgia Plan program, and also that the three Blue Shield plans in Georgia be invited to be represented by both an M.D. and laymen at this meeting.

Georgia Plan Fee Policy—John Elliott asked the approval of the Insurance and Economics Committee

which was given on the following items:

Miscarriage without dilation and curettement—no payment, as this is medical treatment.

Burns on children with debridement—O.K. and pay.

Hematoma—no payment.

Hysterectomy and vaginal hysterectomy with repair—Question as to whether the fee for these two procedures should be the same; they are now different. (This question was taken under advisement and no conclusion reached.)

Payment of the original fee of epitheliomal which should be \$25.00 instead of \$20.00.

Rural Health Committee Insurance Check List—Mr. Krueger presented a request of the Rural Health Committee asking that certain members of the Insurance Board prepare a "check list" on factors that make for a good health insurance plan. This "check list" would be of a general nature and would then be distributed to the public in rural areas. This request was approved, and the chairman appointed Drs. Wolff, Elliott, and Jones to work on this matter.

There being no further business, the meeting was adjourned.

MATERNAL AND INFANT WELFARE COMMITTEE

CHAIRMAN CHARLES M. MULHERIN, Augusta, called the meeting of the Maternal and Infant Welfare Committee to order at 10:30 a.m., June 9, 1957, Academy of Medicine, Atlanta.

Members present included Charles M. Mulherin, Augusta, Chairman; Helen W. Bellhouse, Atlanta; and Eugene L. Griffin, Atlanta. Also present was Mr. M. D. Krueger, MAG Headquarters Office, Atlanta.

AMA Guide for Maternal Death Study—This guide was discussed, and it was believed that "Part III—Non-related Causes" should be added to include items A through H on page 13. Further discussed in this guide was Part II, No. H, page 7, and it was recommended that the parenthetical items be deleted and that "(such as puerpal psychoses)" be substituted. Under G of Part II, it was recommended that Numbers 1, 2, 3, and 4 of Part II, H, be added.

It was further recommended that the word "avoidability" should be used in place of the word, "preventability" in relating to the committee's judgment on cases presented to them. Members of the committee also discussed the sample letter to the physicians (final report) and decided that a letter based on AMA specimen letters be used.

Review of Unanswered Cases—It was found that there were 13 cases with no replies from physicians (after these physicians had been sent three letters). It was recommended that these physicians be called and asked to reply.

It was further recommended that a copy of each letter should be placed on file with the certificates, and letters to hospital administrators, especially, should be individualized by the chairman, and further that in some cases, a special letter from the chairman should be sent to the individual physician, particularly in home delivery conditions.

Case Study—Individual cases reviewed by Drs. Hydrick, Bickerstaff, and Griffin were reviewed by the committee and form 6957 MAG was filled out for each case and given to Dr. Bellhouse for final processing and mailing.

Perinatal Mortality Subcommittee—Appointed to the Perinatal Mortality Subcommittee were the following physicians: H. F. Sharpley, Jr., Savannah, Chairman; Dan Bruce Kahle, Atlanta; E. C. McMillan, Macon; Charles G. Green, Waynesboro; Thomas C. McPherson, Atlanta; and James W. Bennett, Augusta. Mr. Krueger was instructed to inform those members of their appointments.

The committee discussed its proposed expenditures in considering the possibility of travel to the American Maternal Welfare Association in July, and to the Daytona Obstetric and Pediatric Seminar in September. In view of the short time before the American Maternal Welfare Association meeting, it was decided to spend funds only for a representative to the Daytona Obstetric and Pediatric Seminar to be held September 9-11, 1957.

There being no further business, the meeting was adjourned.

ANNOUNCEMENTS

Medical Economics Awards—The following awards have been announced by *Medical Economics*, the national business magazine for physicians: Top award of \$500 will go to the physician submitting the best original articles during the year. Awards ranging from \$300 to \$100 will be made for other original articles written by physicians and accepted for publication; \$50 will be given for article ideas submitted by physicians and approved by *Medical Economics'* staff. Articles should be limited to one aspect of any broad relative subject and should be between 1,000 and 3,000 words. For detailed information write to Awards Editor, *Medical Economics*, Oradell, N. J.

Postgraduate Courses in Clinical Medicine—Mount Sinai Hospital, New York. Given in affiliation with Columbia University and designed to offer facilities of The Mount Sinai Hospital for continuation training and advanced experience in the clinical fields of medicine. Length of courses range from one week to several months. Included in the program are courses in Hematology, Internal Medicine, Pathology, Neurology, and Radiology. Further information may be obtained by applying to the Registrar for Postgraduate Medical Instruction, The Mount Sinai Hospital, Fifth Avenue and One-Hundredth Street, New York 29, N. Y.

DEATHS

J. WALLACE DANIEL, 85, retired Claxton physician, died at his home on June 26, following a long

illness.

A native of Liberty County, Dr. Daniel had practiced medicine in Evans County for 55 years. He had been president of the Midway Association for the past 15 years and was a former state senator. He was first chairman of the Evans County Board of Health and was instrumental in obtaining the county health clinic. For 25 years Dr. Daniel served as chairman of the board of stewards of the Claxton Methodist Church.

Survivors include his wife, Mrs. Possie B. C. Daniel; four sons, Dr. Bird Daniel, navy Capt. J. W. Daniel, Jr., Comdr. J. S. Daniel, and Mr. R. L. Daniel; one daughter, Mrs. Robert H. Lawson; two sisters, Mrs. G. D. Dorrough and Mrs. D. B. Rustin; and 14 grandchildren.

LAWSON THORNTON, Atlanta orthopedic surgeon, died at his home on June 26.

Dr. Thornton was born in Talladega, Alabama, and had made his home in Atlanta since World War I. He served as captain in the Medical Corps during the war.

He was a graduate of the Alabama Polytechnic School and of Johns Hopkins University School of Medicine.

Dr. Thornton was a member of the Fulton County Medical Society, the Georgia Medical Association, a fellow in the American College of Surgeons, a member of the American Orthopedic Association and of the Sir Roger Jones Orthopedic Club. Prior to his death he was on the staffs of Piedmont Hospital, St. Joseph's Infirmary, and Grady Hospital.

Surviving are his wife; one daughter, Mrs. Allen W. Hill, Atlanta; and a sister, Miss Eugenia Thornton, Talladega.

SOCIETIES

The annual "President's Dinner" of the GEORGIA MEDICAL SOCIETY, Savannah, was held recently honoring the immediate past president, Ruskin King. Thomas A. McGoldrick presided as toastmaster at the dinner.

Principal speaker at the June meeting of the GEORGIA MEDICAL SOCIETY, Savannah, was John H. Angell who spoke on "Experiences of Savannah Tumor Clinic in Treatment of Carcinoma of Cervix."

At a recent meeting of the BALDWIN COUNTY MEDICAL SOCIETY, Oscar S. Spivey and Ralph G. Newton, Jr., both of Macon, gave a discussion on "Electrolyte Imbalance and Treatment."

PERSONALS

New members of the State Medical Education Board of Georgia include W. BRUCE SCHAEFER, Toccoa, president of the Medical Association of Georgia; HERMAN L. DISMUKE, Ocilla; J. C. TANNER, JR., Atlanta; and RAYMOND D. EVANS, Clayton. HAL M. DAVISON, past president of the MAG, is the only carry-over member.

First District

HYLAN F. BENT, Midville, was presented with a bronze tablet at recent ceremonies honoring two Midville physicians. The tablet was given to Dr. Bent as a token of appreciation for his 51 years of contribution

to medicine and citizenship. At the same ceremony a monument was unveiled in memory of the late WILLIAM R. LOWE who served as a community physician in Midville for about 50 years.

LAWRENCE S. BODZINER, Savannah obstetrician and gynecologist, has been certified as a diplomate of the American Board of Obstetrics and Gynecology. Dr. Bodziner is chief of the section of obstetrics and gynecology at St. Joseph's Hospital and directs the resident training program in OB and GYN at Memorial Hospital. He is also an active staff member of the Warren A. Candler Hospital and the Georgia Infirmary.

HUBERT L. KING, Statesboro, Medical Director of the District 7, Health Department, attended a meeting of Public Health Medical Directors in Macon recently.

F. Debele Maner, son of DR. and MRS. E. N. MANER, Savannah, recently received his medical degree from the Medical College of Georgia.

H. E. ROLLINGS, Savannah, received his certificate of fellowship in the American College of Chest Physicians at the annual meeting of the college in New York in June.

Announcement has been made that H. F. SHARPLEY, JR., W. W. OSBORNE, and J. J. DOOLAN, Savannah obstetricians and gynecologists, have purchased the old Ives home and former residence of the late THOMAS J. CHARLTON to use for offices. The building will be occupied in October.

Second District

A. G. FUNDERBUNK, Moultrie, announces the removal of his office from 122 South Main Street to 317 South Main Street.

"F. P. PICKETT DAY" was observed recently in Ty Ty, honoring Dr. Pickett who was chosen Georgia's "Practitioner of the Year" by the Georgia Medical Society.

It has been announced that E. B. SAYE, Thomasville, has resigned as pathologist at Archibald Memorial Hospital. Dr. Saye, who has been head of the pathology department for 10 years, has now begun work at the Milledgeville State Hospital.

J. WALTER SMITH, Arlington, has recently opened offices for the practice of general medicine at the Arlington City Hospital. Dr. Smith is a graduate of Emory University and the Medical College of Georgia. He interned at Central Dispensary and Emergency Hospital, Washington, D. C., and since his internship he has served for three years as rotating resident and senior physician at Milledgeville State Hospital.

Third District

M. F. ARNOLD, Hawkinsville, was one of the principal speakers at the Junior-Senior Day program at the Georgia Medical College at Augusta. Dr. Arnold spoke on the duties of the young doctor in a small town, emphasizing the importance of participation in civic activities.

JACK HIRSCH, Columbus, gave a talk on the local alcoholic problem at a recent meeting of the Muscogee County Planning Council.

PERSONALS CONTINUED

R. C. PENDERGRASS, Americus physician and authority on the nearby Andersonville prison, was asked to study for authenticity a television script concerning an early historical event in the prison.

Fourth District

E. T. ARNOLD, JR., Hogansville, has announced that William T. Tippins of Claxton is now associated with him in the Arnold Clinic. Dr. Tippins completed his internship in June at Athens General Hospital. He is a graduate of the Medical College of Georgia at Augusta.

E. JORDAN CALLAWAY, Covington, has been named City Physician to succeed the late Clarence Palmer. Dr. Callaway began his practice in Covington in 1952 and until a few months ago was Chief of Staff at Newton County Hospital.

G. R. FOSTER, JR., McDonough, announces the removal of his office to the Masonic Building.

Fifth District

At a recent meeting of the American College of Chest Physicians in New York, OSLER A. ABBOTT, Emory University, was re-elected Governor of the college for Georgia.

VERNELLE FOX, Atlanta physician, recently addressed the newly formed Metropolitan Atlanta Committee on Alcoholism. Dr. Fox spoke on the psychological aspects of alcoholism.

MILTON H. FREEDMAN, Atlanta, announces the removal of his offices to 34 Boulevard, N.E.

While flying his single-engine plane to New York last June, WARREN W. GREMMEL, Atlanta, experienced navigation trouble and was forced to land on a busy US highway near Richmond, Virginia. Dr. Gremmel reported a similar incident last summer when he made a forced-landing on a private flying strip.

J. WILLIS HURST, Emory University, discussed Atlanta as a medical center at a luncheon meeting of the Atlanta Kiwanis Club.

WILLIAM D. LOGAN, JR., and JOSEPH A. WILBER, Atlanta, members of the Grady Hospital staff, will spend the coming year in England. Dr. Logan will study chest surgery at Guy's Hospital in London; Dr. Wilber will study high blood pressure at Oxford University, Oxford, England.

JOHN D. MARTIN, JR., clinical professor of surgery at Emory University School of Medicine, has been named chairman of the department of surgery. He will fill the position opened by the resignation of JOHN M. HOWARD earlier this year. Dr. Martin is a graduate of Emory Medical School and has been a member of the faculty since 1930. He is a fellow of the American College of Surgeons, a diplomate, American Board of Surgery, and a member of the International Society of Surgery. Dr. Martin is also associate editor of *The American Surgeon* and the author of numerous articles in medical journals in the general field of surgery.

CARL C. PFEIFFER, Emory University, has recently been promoted from acting director to director of the

division of basic health sciences. Dr. Pfeiffer joined the Emory faculty as chairman of pharmacology in 1954 and is known for his research in drugs.

Sixth District

CHARLES L. RIDLEY, SR., Macon, has accepted a newly created post of medical director emeritus at Macon Hospital after the Hospital Commission refused to accept his submitted resignation. He had earlier resigned from his post of Bibb County physician, a position now filled by W. E. POUND of Macon. Dr. Ridley graduated from the Medical College of Georgia in 1906 and has practiced medicine in Georgia for more than half a century. He served on the State Board of Health for 15 years and was cited by the Board as a "distinguished medical man of Georgia." The Medical Association of Georgia honored him in 1956 with a 50-year certificate for "outstanding service in the field of medicine."

ROBERT M. WYNNE, Macon, announces the association with him in practice of William O. Williams, Jr., of Macon. Dr. Williams received his A.B. degree from Mercer University and his medical degree from Bowman Gray Medical School of Wake Forest College, Winston-Salem, N. C. He served a rotating internship at Georgia Baptist Hospital in Atlanta and a rotating residency at Macon Hospital.

Seventh District

Ralph W. Fowler, Jr., son of DR. and MRS. RALPH W. FOWLER, Marietta, recently received the Doctor of Medicine degree from the Medical College of Georgia at Augusta.

N. H. HUTCHINSON, Trenton, spoke on polio and the effects of the Salk vaccine at a meeting of the Dade County Jaycettes.

H. L. SAMS, retired Dalton physician, has been awarded a certificate for distinguished service in the medical profession and a 50-year service pin by the Medical Association of Georgia. Dr. Sams attended Grant University for three years and graduated from the Atlanta School of Medicine (now a part of Emory University) and Tulane Medical School. He began the practice of medicine 50 years ago in Bartow County and one year later moved to Dalton, where he has served for almost a half century.

Eighth District

E. A. DANEMAN, Waycross psychiatrist, was the principal speaker at a recent meeting of the Pierce County Mental Health Association. In his speech Dr. Daneman discussed the problems in the recovery of mental patients and a system of education for the exceptional children in Pierce County.

Benjamin H. Minchew, Jr., son of DR. and MRS. B. H. MINCHEW of Waycross, has been awarded his Doctor of Medicine degree at Emory University.

T. L. PARKER, Douglas, addressed a regular meeting of the Douglas Lions Club recently. Dr. Parker's talk was concerned with the introduction of the polio vaccine into the adult group.

WILLIAM P. SMITH, former Atlanta physician, has begun his practice of medicine and surgery in Douglasville in the office formerly occupied by the late R. E.

HAMILTON. Dr. Smith received his B.S. and masters degrees from the University of Georgia School of Medicine, Augusta. He interned at the Baroness Erlanger Hospital in Chattanooga where he later spent three years in surgery residency.

Ninth District

GUY EVERHART and WILLIAM L. CATON, Snellville, recently announced the opening of the Snellville Clinic. Dr. Caton was formerly chairman and professor of the Department of Obstetrics and Gynecology at Emory University. Dr. Everhart was in the practice of general medicine and surgery at Loganville Clinic.

S. O. POOLE, originally of Gainesville, is now an assistant professor with R. BRUCE LOGUE in cardiology at Emory School of Medicine. Dr. Poole will be engaged in private practice as well as teach in the School of Medicine.

T. J. VANSANT, Woodstock, was honored recently at an open house celebration of his golden anniversary as a practicing physician. Prior to this event the Medical Association of Georgia presented Dr. Vansant with a recognition pin for 50 years of service. Dr. Vansant graduated from the old Georgia College of Eclectic Medicine and Surgery in Atlanta in 1907. Following graduation he practiced in Kennesaw for a few months before moving to Woodstock where he has practiced ever since with the exception of a couple of years spent in Marietta.

Tenth District

THOMAS FINDLEY, Augusta, who has been Professor of Medicine and Chairman of Cardiovascular Research for the Georgia Heart Association at the Medical College of Georgia since May 1954, was named Chairman of the Department of Medicine following the

retirement of V. P. Sydenstricker. Dr. Findley is a native of Omaha, Nebraska. He received his B.A. degree from Princeton University in 1923, an M.A. degree from the University of Minnesota in 1925, and his Doctor of Medicine degree from Rush Medical College, Chicago, Illinois, in 1928. Since entering academic medicine in 1929, Dr. Findley has served as Instructor of Medicine at the University of Michigan; Research Fellow in Pharmacology at the University of Pennsylvania; Assistant Professor of Clinical Medicine at Washington University School of Medicine; Head of the Section of Internal Medicine at the Oschner Clinic in New Orleans; and Professor of Clinical Medicine at Tulane University. Dr. Findley is a member of several professional and scientific organizations and has held offices in a number of these. This year he was named to the Executive Committee of the Advisory Board for Medical Specialties representing the American Board of Internal Medicine and was also made a member of the Residency Review Committee in Internal Medicine of the American Medical Association.

JULIUS T. JOHNSON, Augusta, presented a paper at the 39th clinical meeting of the Southeastern Society of Neurology and Psychiatry in Augusta recently.

J. ROBERT RINKER, Augusta, Professor of Surgery and Chief of Urology at the Medical College of Georgia, has been appointed a member of the Registry of Genito-urinary Pathology of the American Urological Association.

CHARLES E. WILLS, JR., Washington, has announced that Robert Shearouse is now in association with him in the practice of medicine. Dr. Shearouse received his education at Emory University and the Medical College of Georgia, Augusta, and completed his internship at the General Hospital, Athens.

Georgia Health News

Hospital staffs of 36 counties in southeastern Georgia have been requested to assist with a special study of accidents and injuries involving 1956 and 1957 model automobiles.

Information is being obtained on the degree of protection offered by such safety innovations as spring-proof door latches, energy-absorbing steering wheels, dashboard and visor, padding, seat belts and the like.

The study, known as Automotive Crash Injury Research Project, is being conducted by the Georgia State Patrol and the Georgia Department of Public Health, in cooperation with the Medical Association of Georgia. The Department of Public Health and Preventive Medicine of Cornell University Medical College, New York, New York, is the coordinating agency for the interstate program.

A study of accident-injuries of 1956 model automobiles, as compared with the accident-injury experiences of older model cars, has shown 25 per cent reduction in the risk of dangerous through fatal grade injury.

Studies by Georgia police and medical groups are

aimed at obtaining data through the use of sampling areas which will reflect statewide geographic and traffic situations. Individual troop areas will be studied for a period of six months. Starting June 1, the counties of Long, Liberty, Bryan, Dodge, Telfair, Coffee, Wheeler, Montgomery, Jeff Davis, Toombs, Tatnall, Evans, Treutlen, Emanuel, Candler, Bulloch, Laurens, Johnson, Wilkinson, Washington, Twiggs, Jenkins, Screven, Effingham, Burke, Atkinson, Clinch, Charlton, Ware, Brantley, Pierce, Bacon, Appling, Wayne, Camden, and McIntosh became the first to be studied.

Investigating State Patrol officers will report exact causes of injury and include photographs showing car damage and all pertinent accident details. Physicians treating accident victims are asked to complete a brief medical report form giving the specific nature, location, and extent of injuries. Copies of forms used in these medical reports, together with a kit containing other data of the study, have been distributed to hospital administrators in the area involved in the study.

Because of the nature of the information to be

received, these report forms will usually be handled in hospitals. Investigating officers have been instructed to provide the necessary forms to the emergency room supervisor, or the nurse in the office of individual physicians. Procedures have been established whereby the physician or hospital staff will record the required information concerning the accident victim's injuries.

These reports will be collected by the Georgia Department of Public Health and correlated before submission to Cornell University Medical College for analysis and statistical tabulation.

Hospital Care for the Underprivileged

A state program of financial assistance for Georgians unable to pay for hospital care is being planned by the Hospital Care Council which was established by the last session of the General Assembly.

The Council met July 17 in Atlanta to establish principles from which plans will soon be worked out in detail.

The Council will request temporary operating funds from the Budget Bureau until formal plans can be presented to the 1958 General Assembly.

Oscar S. Hilliard, administrator of the Tri-County Hospital, for Oglethorpe, and chairman of the Council, announced the following principles which will guide the development of the program:

1. Counties wishing to receive funds for hospital care of patients who cannot pay must also put up matching funds on a formula to be developed later.
2. Proprietary, or profit-making hospitals, will be paid a flat sum unless they furnish acceptable information as to per diem cost for patients. Hospitals must also have provisional or annual licensure permits as determined by the Georgia Department of Public Health.
3. Hospitals eligible for funds must have at least 10 beds and meet minimum requirements for registration with the American Hospital Association.
4. Local screening boards for determining eligibility of patients will have representatives of local welfare department, a physician and laymen.
5. A total of not more than 30 days per year hospital care will be allowable.
6. Counties whose hospitals are used by neighboring counties without hospitals will have priority on the funds of the neighboring counties. Likewise, when patients from counties with hospitals cross county lines, the funds will follow the patients to the county rendering the services.

The Council also announced names of officers and members. In addition to Chairman Hilliard, officers are Frank W. Allcorn, Warm Springs, vice-chairman, and John W. Collins, Jr., Atlanta, secretary. Members representing the Association of County Commissioners are George L. Matthews, Americus, and Mr. Allcorn; representing the Medical Association of Georgia are Dr. A. B. Conger, Columbus, and Dr. Bruce Schaefer, Toccoa; representing the Georgia Association of Hospital Governing Boards are Frank L. Baker, Jr., chairman of Floyd County Hospital Authority, Rome, and James E. Evitt, member Tri-County Hospital Association, Ringgold; representing the Georgia Hospital Association are Mr. Hilliard and O. B. Hardy, administrator of Phoebe Putney Memorial Hospital, Albany; representing the public at large are Mr. Collins of WAGA-TV, Atlanta, E. H. Kalman, Albany businessman, and Jeff Gilreath, Cartersville manufacturer. Ex officio members are Dr. T. F. Sellers, director of the Georgia Department of Public Health, and Alan Kemper, director of the Georgia Department of Public Welfare.

Hospital Food Equipment Courses Offered in September

Food service and dietary personnel in hospitals and other institutions in Georgia are invited to free one-day courses in September on use and care of equipment.

The courses, to be held in four areas of the state, will feature lectures, films, and demonstrations of institutional kitchen equipment. They are especially designed for dietitians, food service supervisors, and kitchen managers.

The morning sessions include "Sanitation in Use and Care of Equipment"; a film on making large quantities of coffee, "Specialty of the House"; and a discussion of equipment maintenance programs. The afternoon sessions will continue the equipment maintenance program, and the final session will evaluate the day's activities.

Hours for the courses are 9:00 to 4:30 p.m. They will be held at hospitals representing the Hospital Council areas of the state. These are Tri-County Hospital, Fort Oglethorpe (Northwest), September 12; Athens General Hospital (Northeast), September 17; and Emanuel County Hospital, Swainsboro (Southeast), September 19. Announcement will be made later of a course in a hospital representing the Central and Southwest areas.

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Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

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Conquest of the Atom—Photos by Ted F. Leigh and World-wide Photos

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STATEMENT ON ASIAN INFLUENZA

by

GEORGIA DEPARTMENT OF PUBLIC HEALTH, ITS INFLUENZA ADVISORY
COMMITTEE AND MAG PUBLIC HEALTH COMMITTEE

Dear Doctor:

In the belief that too much has already been said in the public press relative to Asian flu and that it might be helpful for you to have a statement of the views of the Georgia Department of Public Health and its Advisory Committee, representing the Medical Association of Georgia, Georgia Academy of General Practice, Georgia Pediatric Society, and the Georgia Pharmaceutical Association, we are writing you this letter.

There seems little doubt that we can expect a considerable number of cases of influenza during this fall and winter, which is clinically no different from the influenza seen each year. However, for the first time in history, a new immunological strain of virus has been isolated in advance of an epidemic for the development of a vaccine which is expected to be specific and effective in preventing infection with this virus strain.

The major problem lies in the fact that while the vaccine is in production and scheduled to be available in adequate quantities not later than the first of the year, the upswing in infection may well occur prior to that time.

We, therefore, believe, while there is no cause for alarm, there is reason for concern that the vaccine, while limited in amount, be used in the most effective manner. Recommendations of the Surgeon General, Georgia Department of Public Health, and its Advisory Committee on Influenza, therefore, propose that priority for recipients of vaccine be as follows:

- (1) Individuals whose services are necessary to maintain the health of the community.
- (2) Individuals necessary to maintain other basic and essential community services.
- (3) Persons with existing disease who, in the opinion of their physician, constitute a special medical risk.
- (4) Children and adults over 40.

The best information now available on effective dosage of the monovalent vaccine for the Asian strain of influenza is as follows:

For preschool children (three months to five years): 0.1 cc intracutaneously or subcutaneously, repeated after an interval of two weeks.

For children five to 12 years of age: 0.5 cc subcutaneously, repeated after an interval of one to two weeks.

For persons 13 years of age or older: 1.0 cc subcutaneously in a single injection.

This vaccine is a chick embryo vaccine and should not be given to individuals with egg or chicken sensitivity.

The best information available at this moment from the use of this specific vaccine is that *not more than five per cent* of individuals receiving it will have local or systemic reaction and only a small percentage of them will be severe enough to cause any loss of time.

It is believed that the uncomplicated case of influenza runs less risk of acquiring cross infection if cared for at home rather than in the hospital.

As you probably know, the vaccine is being manufactured by six companies and, while allocated to the states on a population ratio, it is being distributed without controls through normal commercial channels by these companies.

Sincerely,

T. F. Sellers, M.D.

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(Editor's Note:—The letter above has been mailed to all physicians in the state and is published here for your information. Additional material on Asian Influenza will be forthcoming from the Public Health Committee of the Medical Association of Georgia.)

TENTATIVE PROGRAM

GEORGIA ACADEMY OF GENERAL PRACTICE

9th Annual Session—October 23-24, 1957

Crystal Room

Bon Air Hotel, Augusta, Georgia

—WEDNESDAY—

- 10:00 a.m.—Title to be Announced—William W. Waddell, Charlottesville, Virginia, Chairman of the Pediatric Department, University of Virginia
- 10:30 a.m.—“THE MASTER TWO-STEP EXERCISE TEST,” Arthur M. Master, New York City
- 11:00 a.m.—VIEW EXHIBITS
- 11:30 a.m.—“ACTIVITIES OF THE AAGP,” Malcom E. Phelps, El Reno, Oklahoma, President, American Academy of General Practice
- 1:30 p.m.—“THE MODERN CONCEPTS IN THE TREATMENT OF ACUTE CORONARY DISEASE,” Arthur M. Master, New York City
- 2:00 p.m.—ESTIMATION OF FRACTURE AS TO MODE OF TREATMENT AND RESULT OBTAINABLE—David M. Bosworth, New York, Professor of Orthopedic Surgery, College of Physicians and Surgeons
- 2:30 p.m.—VIEW EXHIBITS
- 3:00 p.m.—“THE INTERRELATIONSHIPS OF THE SEVERAL COLLAGEN DISEASES, THEIR DIAGNOSIS AND MANAGEMENT,” R. H. Kampmeier, Nashville, Tennessee, Professor of Medicine, Vanderbilt University School of Medicine
- 3:30 p.m.—Symposium on “MANAGEMENT OF TUBERCULOSIS BY THE GENERALIST ON A LOCAL LEVEL”—
William Hopkins, Atlanta
R. F. Corpe, Rome
R. H. Kampmeier, Nashville
Sam Patton, Macon,
Moderator

BANQUET SPEAKER—Russell B. Roth, Erie, Pennsylvania
“PUBLIC RELATIONS”

—THURSDAY—

- 9:30 a.m.—“ACCIDENTS FROM USE OF LOCAL ANESTHETICS” — John Adriani, New Orleans, Louisiana, Director, Department of Anesthesia, Charity Hospital
- 10:00 a.m.—“CARCINOMA OF THE PROSTATE AND THE FAMILY PHYSICIAN”—Russell B. Roth, Erie, Pennsylvania
- 10:30 a.m.—VIEW EXHIBITS
- 11:00 a.m.—“METHODS OF APPROACH AND MANAGEMENT FOR THE PATIENT WITH GASTROINTESTINAL HEMORRHAGE,” R. Russell Best, Omaha, Nebraska, Professor of Surgery, University of Nebraska College of Medicine
- 11:30 a.m.—“STRESS”—Floyd R. Skelton, New Orleans, Louisiana, Director of Research, The Urban Maes Research Foundation, Louisiana State University Medical School
- 1:30 p.m.—“HYPOTHERMIA,” Malcom E. Phelps, El Reno, Oklahoma
- 2:00 p.m.—“INDICATIONS FOR INTERFERENCE DURING NATURAL CHILD-BIRTH,” Clyde L. Randall, Professor, Obstetrics and Gynecology, University of Buffalo School of Medicine, Buffalo, New York
- 2:30 p.m.—VIEW EXHIBITS
- 3:00 p.m.—“THE OFFICE MANAGEMENT OF DIABETES MELLITUS”—Henry T. Ricketts, Chicago, Illinois, Professor of Medicine, University of Chicago, The School of Medicine

THE MARFAN SYNDROME

A case of previously undiagnosed Marfan's Syndrome is presented.

The cardinal features of this heritable disorder are discussed.

ARTHUR M. KNIGHT, JR., M.D., *Waycross, Georgia*

THE MARFAN SYNDROME is a "heritable disorder of connective tissue"¹ characterized by excessive length of the long bones, thin extremities, hyperextensible joints, ectopic lenses, defective elastic tissue, hernias, and cardiovascular lesions such as degeneration of the media of the aorta with dilatation, dissecting aneurysm, and aortic regurgitation. It is thought to be due to a single mutant gene and to be inherited as a Mendelian autosomal dominant. The disorder is thought to occur in very mild form (*forme fruste*) in an appreciable number of affected individuals.^{2,3,4} The full-blown case is likely to be tall and thin with loose joints, long, slender fingers and toes, a malformed chest wall, kyphoscoliosis, and flat feet. He is likely also to be near-sighted and to have ectopic lenses and possibly cataracts. He may have an inguinal, femoral, or an esophageal hiatal hernia. On auscultation of his heart, one is likely to hear an aortic diastolic murmur or some other sign of organic heart disease.^{5,6} Table I summarizes the anatomical and physiological defects one may encounter in the affected individual.¹

Probably at least 350 cases of the Marfan syndrome have been reported in the literature, but McKusick believes¹ that no more than 15 per cent of all cases are derived from *de novo* mutation as opposed to inherited cases. The author believes the

case reported herewith to belong to a family in which the defect has not been reported previously.

This syndrome has been called "arachnodactyly" (spider fingers) and "dolichostenomelia" (long, thin extremities). It is probably frequently misdiagnosed because, although it was described 60 years ago (by a French pediatrician), most physicians are unfamiliar with the syndrome. Thus, in the case reported here, several eye operations were done, an orthopedist operated on the ankles for "polio deformities," and a distinguished cardiologist treated the patient for "rheumatic heart disease." Dr. McKusick has encouraged the author⁷ to report the case because he believes the disease is not rare¹ and may be of concern to the general practitioner, internist, pediatrician, ophthalmologist, orthopedist, general surgeon (hernias), gastroenterologist (hiatal hernia), cardiologist, chest physician (cystic disease of lung, rupture of lung), endocrinologist, pathologist, radiologist, and medical geneticist. It is extremely important for the cardiologist because it is the leading cause of dissecting aneurysm in persons under age 40.

The sexes are equally affected, though aortic disease is more common in the male. There is no special racial predilection. This syndrome must be considered when a patient is seen with a combination of lesions of the eye, skeleton, and cardiovascular system. It is said that 70 per cent of cases of

congenital ectopia lentis are due to Marfan's syndrome. One should hesitate to make the diagnosis unless some stigmata of the disorder can be found in relatives of the patient. If aortic regurgitation is present, syphilis, rheumatic heart disease, bacterial endocarditis, and traumatic rupture of an aortic cusp should be ruled out. Asthenia or dolichostenomelia are helpful but not essential to the diagnosis. The measurements of span, trunk, and extremities help but are not conclusive. Arachnodactyly may be absent but helps to make the diagnosis when present. In making the diagnosis, one must rule out deformities due to maternal rubella, other deleterious intra-uterine influences, and Rh incompatibility.

There is no specific pathological lesion in this disorder except for changes in the media of the great vessels and in the heart valves. The early changes in the aorta are cystic medial necrosis: mild to moderate degeneration of elastic fiber elements and more or less striking cystic areas filled with metachromatically staining material. The advanced changes in the aorta consist of (1) fragmentation and sparsity of elastic fibers, (2) irregular whorls of smooth muscle, (3) increase in collagen, (4) increased vascularity of the media, (5) cystic spaces occupied by metachromatically staining material, and (6) an aortic wall thicker and weaker than normal. The pulmonary artery may also be involved. Minor changes may occur in the heart valves, such as marginal thickening. It is interesting that an analogous but acquired

syndrome can be produced in rats by feeding seeds of *Lathyrus odoratus* (sweet pea).¹

Case History

B. R. (Fig. 2), a 43-year-old, white, single female was admitted to the hospital on April 21, 1956, complaining of dyspnea and cough. Past history revealed that a chest deformity had been present at birth and that she had always been sickly and undernourished. She was a tall, skinny child. (Fig. 3). "Curved and twisted ankles" were first noticed at age 7 years and mild kyphoscoliosis at age 14, neither deformity being severe at first. She had had backaches since age 14. The ankles "would get out of place and could be pushed back." Eventually the left ankle "started growing out of place," but surgery to stabilize it was not done until 1936. Menarche occurred at age 16.

Several eye operations were done, beginning at age eight. The left eye was needled once a week for several weeks "because of a dislocated lens," but finally "the fluid ran out and the eye became blind"; so it was enucleated. The right lens was removed in 1949 and the retina became detached, producing almost total blindness.

She worked on the family farm and as a beautician until a "nervous breakdown from overwork" in 1943, after which she did clerical work until she lost her vision. She said she was always "very strong" until she became anemic in 1943, having

TABLE 1.

Summary of Anatomical and Physiological Defects in
The Marfan Syndrome¹

HABITUS:	tall, thin, long extremities. Lower measurement greater than upper measurement. Span greater than height.
SKELETON:	kyphoscoliosis, pectus excavatum, pigeon breast, long digits, flat feet, genu recurvatum, recurrent dislocations, hyperextensible joints.
MUSCULATURE:	underdevelopment and hypotonia.
CONNECTIVE TISSUES:	redundancy and weakness of joint capsules, ligaments, tendons, fascia. Ganglia, hernias, synovial diverticula. Sparsity of subcutaneous fat.
EYE:	redundant suspensory ligament. Ectopia lentis. Myopia. Retinal detachment. Iritis. Glaucoma. Cataract. Blindness.
CARDIO- VASCULAR ⁶	inborn weakness of media (aorta and pulmonary a.) Degeneration of media. Diffuse dilatation of ascending aorta. Dilatation of main pulmonary a. Dissecting aneurysm. Stretching of aortic cusps. Aortic regurgitation. Redundant mitral cusps and chordae tendineae. Mitral regurgitation. Atrial septal defect.



Figures 2 and 3: Photos of patient at 28 and 12 years respectively.

had recurrent anemia ever since. Menses had for several years lasted 7 days. For many years she had complained of post-prandial belching, bloating, and heartburn. Her right foot had cramped since age 19. Because it was thought that she had had polio, she was treated at Warm Springs in 1949 and an operation was later done on her left ankle. Her left hip used to be "numb and tingly" during the years when her scoliosis was developing. In 1953 traction was applied to the left lower extremity by an orthopedist for a brief time.

She said she could tell there was something wrong with her heart as long ago as 1946 because "it used to beat too fast." She also remembered that it would "thump and race a lot" in 1949. She had complained of fatigability since 1943. She was seen by a cardiologist in October 1954 and told that she had had rheumatic fever and that she now had chronic rheumatic heart disease. For the past year her heart had been "thumping and racing" quite a lot, though the spells lasted for only a few seconds. She first noticed exertional dyspnea in early 1955 and marked dependent edema first appeared in January 1956.

(Figure 4) On physical examination the most striking findings were the blindness, the kyphoscoliosis, and the marked chest deformity. She was rather thin, being 63½ inches tall and weighing 104 pounds (Figure 5) Temperature was 98.6, pulse 100, and B.P. 130/50. The left eye was artificial and there was a coloboma of the right iris. (Figure 6). A prominent pulsation was noted at the root of the neck. The right lens was missing. The pupil reacted to light but vision was almost completely gone. The teeth were irregular and overlapping and the palate was unusually high and arched. The tonsils had been removed. The trachea was displaced considerably to the left. The hands and fingers were long and slender. (Figure 7). The span was 70½ inches, lower measurement 36½ inches, and upper measurement 27 inches. (Figure 8). Breasts were normal. At the level of the nipples, the sternum was very prominent, but it was bent back acutely upon itself in the distal portion. The area of cardiac dullness was



Figure 4: Anterior view of patient standing to show habitus.



Figure 6: Close-up of patient's face to show appearance of eyes. Left eye is artificial. Right eye contains a coloboma of the iris.

Figure 5: Lateral view of patient to illustrate chest deformity and hyphosis. Patient stands 63½ inches tall and weighs 104 pounds.



Figure 7: Hands of patient beside those of a normal woman, to illustrate arachnodactyly.

displaced to the left with the left border of dullness almost out to the anterior axillary line in the sixth and seventh interspaces, and the PMI was in the nipple line in the sixth. Here was a loud (grade iii) diastolic murmur heard over the entire precordium with greatest intensity at the aortic area and transmitted down the right side of the sternum. This murmur had both a low-pitched component and a high-pitched, musical component. There was also a brief, low-pitched, rumbling, early systolic aortic murmur of grade ii intensity. A good second sound could be heard at the aortic area. There was marked kyphosis of the spine at the lower dorsal and upper lumbar level with marked convexity towards the left at this same level. (Figures 9 & 10). Breath sounds were distant over the lung bases but of good quality elsewhere. Moist rales could be heard faintly over the bases. The abdomen was negative. Good femoral



Figure 9: Rear view of patient showing the scoliosis.



Figure 8: Semi-lateral view of patient standing to illustrate chest deformity and long arms.

pulses were present. The ankle jerks were absent. Marked pes planus was present on the left and the left ankle had been surgically ankylosed. The left leg was two inches shorter than the right. There were good pulsations in both feet. The hymen was intact. Some external hemorrhoids were present. A firm cystic mass the size of a large orange was felt in the right pelvis.

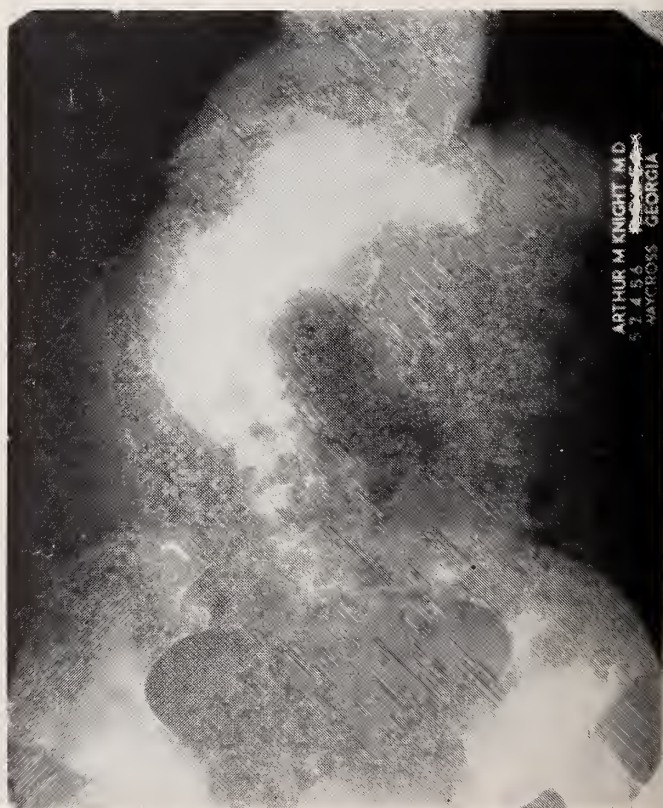


Figure 10: X-ray of lumbar spine to show scoliosis.

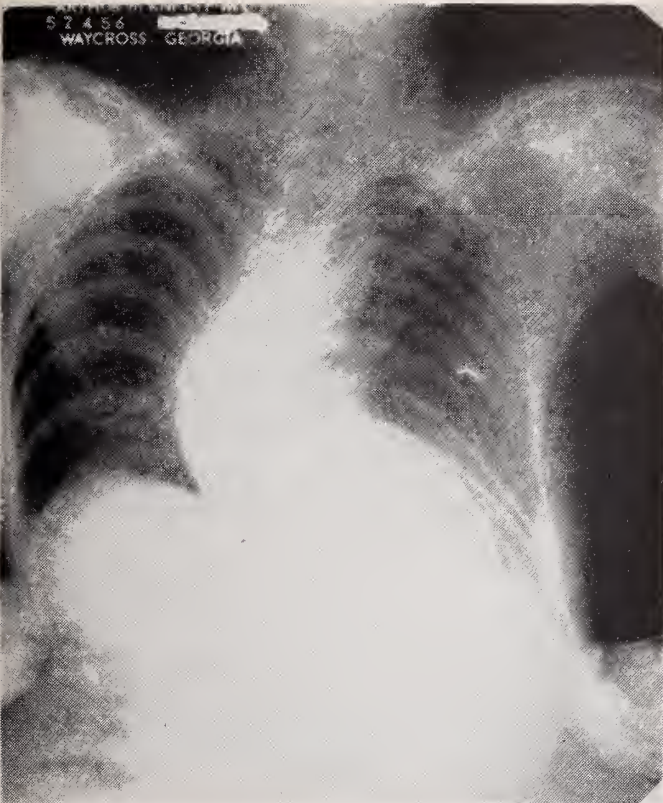


Figure 11: Chest X-ray of patient showing marked scoliosis with displacement of heart to the left.

Urinalysis was negative and routine blood studies were normal except for a hypochromic anemia with a hematocrit of 27. Chest X-ray (Figure 11) revealed the marked scoliosis with displacement of the heart to the left and a probable large esophageal hiatal hernia. (Figure 12). Fluoroscopy revealed marked left ventricular hypertrophy, slight dilatation



Figure 12: Lateral chest X-ray of patient to show sternal deformity.

of the ascending aorta, and confirmed the presence of the hiatal hernia. (Figure 13). E.C.G. showed left ventricular hypertrophy and strain.

Treatment with digitalis, diuretics, and low sodium diet greatly alleviated the cardiovascular symptoms. A bland diet and antacids relieved the G.I. symptoms, and the anemia responded to the administration of iron.

Examination of several of the patient's relatives revealed the findings noted below:

Brother, G.R., age 34 (Figure 14) has a high, arched palate and flat feet: He has a late, systolic, blowing apical murmur, grade ii in intensity and transmitted to the left axilla. His pulse rate is 72 with occasional P.C.'s. B.P. 110/70. Fluoroscopy of the chest and E.C.G. are both normal. He has never had acute rheumatic fever. The murmur was discovered in the army in 1942.

Mother, H.L.R., age 72, has marked pes planus which also afflicted all of her sibs and her mother. She has worn glasses since adolescence for myopic astigmatism.

Sister, M.B., age 45, has astigmatism and mild pes planus.

Brother, K.R., age 47, has a high, arched palate and marked pes planus and has been photophobic all his life.

Nephew, T.R., age four and niece, J.R., age two, children of K.R., have pes planus.

Aunt, Y.T., father's sister, age 67, has a high, arched palate and a tendency to pes planus.

Nephew, L.R., age 12, son of oldest brother, has slight scoliosis, mild winging of the scapulae, and mild pes planus.

Nephew, (Figure 15), G.W.R., son of brother J.C., age eight, has severe myopia, minor redundancy



Figure 13: Barium-filled stomach to show hiatal hernia.

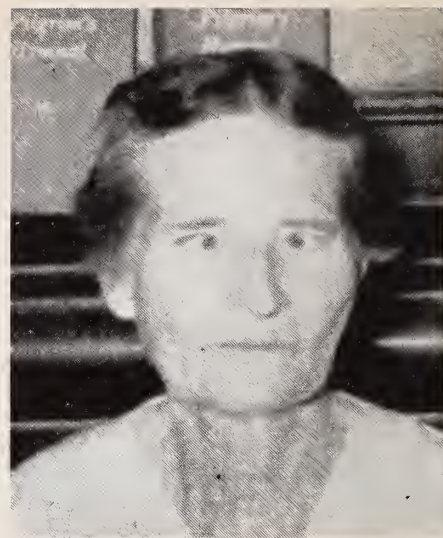


Figure 14 (Upper Left): Photo of brother G.R., age 34, who has a late, systolic, blowing apical murmur, grade II in intensity and transmitted to the left axilla.

Figure 15 (Upper Center): Photo of nephew G.W.R., age eight, who has severe myopia and minor redundancy of the suspensory ligament of the lens.

Figure 16 (Upper Right): Cousin B.B., age 55, showing cataracts and strabismus.

Figure 17 (Bottom Left): Cousin G.B., age 45, showing cataracts and strabismus.

Figure 18 (Bottom Center): Niece A.R., age 18, showing cataract and ectopic lens.



of the suspensory ligament of the lens, and flat feet. He also has mild scoliosis.

Brother, J.C., has a rather high palate.

Second cousin, (Figure 16), B.B., age 55, mother's first cousin, has had eye trouble all her life. Had cataracts in infancy and has had both lenses removed. Has very long great toes.

Second cousin, (Figure 17), G.B., age 45, sister of B.B., has had cataracts all her life. Is flat-footed.

Second cousin, B.B., age 50, brother of B.B. and G.B., reported to be blind since birth.

Niece, (Figure 18), A.R., age 18, daughter of brother L.R., has a congenital cataract and slight ectopia lentis in R.E.

Niece, E.R., age eight, daughter of brother G.R., has a high, arched palate but no other stigmata.

Father's sister had severe myopia.

A brother who was killed in an auto wreck had "a bad heart," and several other members of the family whom I was unable to contact are said to have eye trouble, heart trouble, or murmurs.

Summary

1. The clinical features of the Marfan syndrome are briefly reviewed.

2. A new case is described from a family not previously reported to possess the abnormal gene.

3. Photographs are presented illustrating most of the clinical findings.

4. Stigmata of the abnormal gene and possible examples of the *forme fruste* are illustrated in close relatives of the patient.

Acknowledgment

It would be impossible for anyone to write a paper on this subject without leaning very heavily on the writings and researches of Dr. Victor A. McKusick, Assistant Professor of Medicine in the Johns Hopkins University School of Medicine. His contributions on this subject cited below represent, in the opinion of the author, the highest quality of scientific research and medical writing.

Dr. S. Wm. Clark, Jr., did the eye examinations.

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CLINICAL ACCEPTABILITY OF A CHLORAL HYDRATE- ANTIPYRINE TABLET

An objective clinical appraisal of a new non-barbiturate sedative consisting of a molecular complex of one mole of antipyrine and two moles of chloral hydrate prepared in tablet form.

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FOR THE MAJORITY of patients, the barbiturates have proven to be adequate and acceptable sedatives. There are instances, however, when because of age, adverse mental reactions, or sensitivity phenomena, one prefers to use a non-barbiturate sedative. Chloral hydrate has been used as a satisfactory sedative for almost 90 years. It has the typical central depressant action of the hydrocarbon anesthetics and when used as a sedative usually produces a quiet, restful sleep without major post-sleep, depressive effects. It is known to produce some irritant effects when taken on an empty stomach. It is not analgesic and is, therefore, ineffective as a sedative when the patient has associated pain. It has very few side effects in the usual dosage except for increased frequency of dreams and, rarely, skin eruption.¹ Antipyrine (phenazone) has been used since 1884 as a potent analgesic and to a lesser extent as an antipyretic agent.² The widespread use of this compound has been retarded because it has been confused with aminopyrine. This latter compound has fallen into disrepute because it so frequently produces the serious side effects of agranulocytosis and, occasionally, the appearance of a maculopapular skin rash that may persist for several months after administration of the drug is stopped. Antipyrine is ideally suited for human use inasmuch as it is completely absorbed from the gastrointestinal tract and is metabolized very slowly with effective plasma levels being maintained 15 hours after ingestion.³ No adverse effects were noted in over 200 patients who were given one to one-and-a-half grams of antipyrine intravenously in measurement of total body water,⁴ a dose three to five times greater than the one conventionally employed for analgesia.

Willis and Arendt⁵ have reported that the combination of these two drugs, antipyrine and chloral hydrate, may have synergistic action as a sedative as well as widening the clinical usefulness of chloral hydrate alone by utilizing the analgesic action of antipyrine. Animal studies have indicated synergism in the soporific effect of combinations of chloral hydrate and antipyrine.⁶ The present study was undertaken to determine the effectiveness of dichloralphenazone* (DCP), a molecular complex of one mole of antipyrine and two moles of chloral hydrate prepared in tablet form.⁷

Method of Study

Comparison of Chloral Hydrate and Dichloralphenazone: Eight patients (Group I) were given chloral hydrate, seven-and-one-half grains, for three consecutive nights and then were given DCP, grains x, for three consecutive nights. The drugs were then compared as to subjective sedative efficacy and patient preference.

Relative Acceptability of Dichloralphenazone: Random patients (Group II) were given DCP, grains x nightly, and were questioned regarding the sedative effect, any side effects, and the effect of this compound compared to other sedatives they had used. A total of 23 patients were tested for an average of six nights.

Tolerance of Dichloralphenazone: Four patients (Group III) were given DCP, grain x, as a sedative order for a three months or longer period and were observed to detect the development of any significant toxic reactions. One had been a habitual user of seconal, one a chronic user of chloral hydrate, one an occasional user of seconal, and one had not previously used any sedative.

Results

Group I. Six of the eight patients had a definite

The authors wish to express their appreciation to Mrs. Clarita Faust and to Miss Mary Bell for their assistance in evaluation of patient reactions in this study.

* F.N. Furnished by the National Drug Company.

CHLORAL HYDRATE / Peters

preference for dichloralphenazone while two had no preference for one over the other, but did not dislike the drug. The major reasons for this marked preference were the absence of any unpleasant taste, the lack of stomach burning, and the mechanical ease of taking a pill over a strong liquid medication. No side effects were observed from the use of dichloralphenazone although the use of chloral hydrate for a comparable period of time caused epigastric distress in one, headache in another, and nightmares in a third patient.

	Chloral Hydrate	Dichloralphenazone
Sedation Good	4	6
Unchanged	3	2
Worsened	1	0
Side Effects	3	0
Drug Preference	0	6

Group II. Although group II was evaluated from a purely subjective aspect and with no control other than their previous subjective experience with sedatives, five had a definite preference for dichloralphenazone over any previous sedative; six liked it as well as any sedative, and seven had definite preference for barbiturates. Preferences were difficult to quantitate as they were in the main expressed without formulated reason. The three patients who disliked the drug would give no reason other than that they wanted a barbiturate; and their dislike was not assumed to be based on anything other than the right to refuse to take a different sedative from one used previously. Eleven of this group noticed no change in sleep pattern, seven noticed improvement, five felt that the sleep pattern was made worse by the drug; thus it would appear that the sedative action is roughly equal to that obtained with barbiturates.

A. Sleep Pattern	C. Drug Preference	
Unchanged	11	Liked as well as any 6
Improved	7	Preferred Barbiturates 7
Worsened	5	Disliked Drug 3
B. Side Effects		No Opinion 2
Dizziness	2	
Dreams	2	Total 23
Excitement	4	
None	15	

Group III: This group of patients was small, com-

prising four patients hospitalized for a long period of time due to pulmonary tuberculosis. The drug was exceptionally well tolerated and there were no side effects observed during this period of time. Dichloralphenazone proved to be a completely satisfactory sedative over their extended period of observation.

Discussion

It has been adequately established that the "superiority" of any given sedative or analgesic agent over another is not easy to prove even using the double-blind technique. The present study was not intended to do this. The advantages of a tablet form of chloral hydrate which was essentially tasteless over the unpleasant liquid form generally available were self evident. The synergistic action of chloral hydrate and of antipyrine had long been cited in the literature as established fact.⁶ The intent of this investigation was merely to determine whether the combination would prove to be a satisfactory sedative, and whether toxic effects would become apparent in the course of a short pilot study.

Recognizing these limitations, the significance of the findings seems to be readily apparent. The compound was as well or better tolerated than simple chloral hydrate in comparable dosage; and, as noted by others,⁷ the increased palatability of the material gives it a great advantage in terms of patient preference. Thus the compound promises to be a useful alternative sedation for those individuals who cannot tolerate barbiturates, perhaps for those who are addicted or habituated to them, and for the numerous individuals to whom barbiturate "hangover" represents a contraindication to their use. The relatively good record that both chloral hydrate and antipyrine have held over the years in terms of serious toxic reactions perhaps offers some reassurance to the physician in the use of this compound as compared to some of the newer sedatives which have not enjoyed such a long period of trial and therefore may be a source of idiosyncratic reactions.

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RADIOISOTOPES IN PRIVATE PRACTICE

An outline of the uses and limitations of radioisotopes in clinical medicine.

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PRIOR TO 1952 the administration of artificially produced radioactive isotopes to humans was permitted only in large medical centers, usually universities, where the combined services of a host of experts in different fields were available, but in that year the Atomic Energy Commission agreed to allow qualified physicians to use radioisotopes in private practice. The resulting rapid expansion of the medical application of nuclear energy has prompted many practitioners to consider the advantages offered by the routine use of radioisotopes to their patients and, from an economic viewpoint, to themselves. The following is a brief survey of the most prominent uses of radioisotopes today as well as a hint of what may be expected in the immediate future.

At the present time radioactive iodine, I^{131} , is by far the most commonly used radioisotope. Its value is derived from the inability of thyroid tissue, normal or abnormal, to distinguish between radioactive and stable iodine. Physiological studies have proven that the rate of secretion of thyroid hormone is closely correlated with the rate at which iodine is taken up by the gland; hence, the amount of I^{131} which accumulates in the thyroid area in a given period of time is an accurate index of thyroid activity. This may be determined readily by exposing the neck of a patient to a suitable radiation detector after he has ingested a small dose of radioiodine. The normal twenty-four hour uptake is between 15 per cent and 35 per cent of the test dose. Values below this range indicate hypothyroidism; those above, hyperthyroidism, assuming the absence of complicating factors such as treatment with Lugol's solution, thyroid extract, and other agents which alter thyroid activity.

The radioiodine uptake has several advantages over the usual basal metabolic rate determination as an indication of thyroid activity; the latter is essentially a measure of oxygen consumption and is subject to many neural and humoral influences which are not directly related to the function of the thyroid. In many patients it is difficult, if not impossible, to

obtain a truly basal metabolic rate. This is particularly true in the nervous, anxious individual in whom hyperthyroidism is suspected and the test is of greatest importance. Theoretically, the concentration of inert protein bound iodine in the serum (PBI) is the most direct method of estimating the actual amount of circulating thyroid hormone. Unfortunately, PBI determinations are technically difficult and subject to unpredictable and often undetected errors, such as the presence of traces of iodine vapor in room air, which make this method unsuitable as a routine clinical procedure except under carefully controlled conditions.

By refinement of the radiation detector it is possible to actually outline the thyroid gland, and if a suitable recorder is used, a "map" of radioiodine-containing thyroid parenchyma may be obtained. This is of great value in localizing aberrant thyroid tissue, in finding impalpable nodules, and in distinguishing between active and inactive adenomas.

In diagnostic studies very small doses of radioiodine (25 microcuries or less) are used, and the radiation effect is negligible. When much larger doses (one millicurie or more) are given, the radiation within the gland is sufficient to destroy some functioning acini and depress the activity of the gland. Advantage may be taken of this destructive effect of radioiodine to treat selected cases of hyperthyroidism. It generally is agreed that this is not the treatment of choice in patients under forty years of age or in patients with nodular goiter, but it offers a valuable means of therapy in cases of thyrotoxicosis recurring after surgery and in patients who are poor operative risks. Radioiodine therapy of diffuse toxic goiter is considered by many to be preferable to surgery for the following reasons: there is no morbidity due to the treatment itself, no complications except possible hypothyroidism, and much less expense to the patient since little or no hospitalization is required.

By administering still larger doses of I^{131} (35 millicuries or more) complete ablation of the thyroid gland can be achieved. This has proven to be useful in treating patients who have intractable angina pectoris, congestive heart failure, or pulmonary insufficiency. The rationale is simple. If the heart cannot supply sufficient blood, or the lungs enough oxygen, to satisfy the metabolic demands of the body, the alternative is to decrease these demands by removing the stimulus of the thyroid hormone.

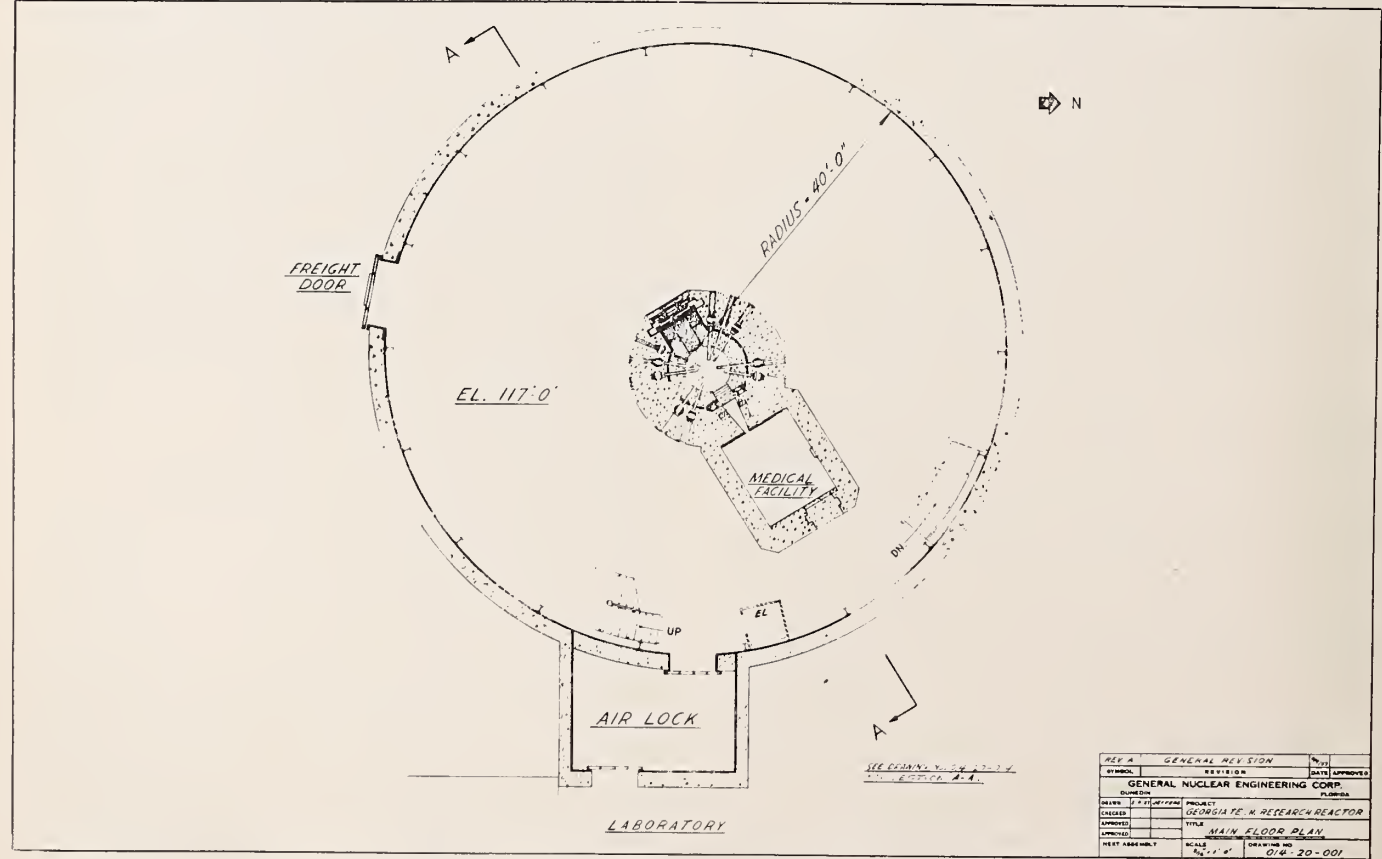
A few years ago there was a great deal of enthusiasm over the treatment of metastatic carcinoma of the thyroid with radioiodine, but most of the early spectacular results have been negated by the later development of generalized anaplastic spread of formerly well differentiated metastases. It is still a question of whether the radioiodine stimulated growth of the malignant cells or simply destroyed the functioning cells and allowed the anaplastic, undifferentiated areas to proliferate. In any case, massive doses (100 millicuries or more) of I^{131} are still given to patients to whom surgery and external x-radiation have nothing more to offer.

A radioactive isotope of phosphorus, P^{32} , is now commonly used in the treatment of blood dyscrasias. By virtue of its incorporation in the nucleoproteins of rapidly maturing cells, particularly those of the hematopoietic system, P^{32} preferentially destroys abnormal cells, just as these cells are more sensitive

to X-rays, nitrogen mustard, and other agents. P^{32} generally is considered to be the treatment of choice in polycythemia vera, is widely used in chronic leukemias, but is contraindicated in acute leukemia.

Radioactive isotopes offer a theoretical advantage over deep X-ray therapy in the treatment of certain neoplastic diseases in that the radiation can be concentrated in the diseased area, sparing the surrounding normal tissues, particularly the skin. Ideally the malignant tissues should have a special affinity for the radioisotope, as in the cases cited of adenocarcinoma of the thyroid for I^{131} and hyperplastic bone marrow for P^{32} . Even in the absence of such an affinity, it is still possible to inject a radioisotope into the malignancy so that it is spread diffusely but is still localized to the involved area. Radioactive gold, Au^{198} , in colloidal form, has been used widely in this manner, and encouraging results have been obtained in inoperable carcinomas of the prostate and the cervix. For some unknown reason the instillation of Au^{198} into the pleural and the peritoneal spaces markedly reduces the rate of accumulation of fluid when these cavities are involved by metastatic malignancies.

A completely new approach to the treatment of cancer which has been suggested recently is the possibility of setting off miniature "atomic bomb" explosions in the cancer itself. The basis of such explosions is the overloading of the nucleus of an



F. J. L. BLASINGAME TO BE AMA GENERAL MANAGER

THE BOARD OF TRUSTEES of the AMA has appointed Dr. George F. Lull, who has been Secretary-General Manager of the Association for 11 years, to the newly created position of Assistant to the President of the AMA. He will continue serving as Secretary, which is an elective office. At the same time, Dr. F. J. L. Blasingame of Wharton, Texas, was appointed to the position of General Manager of the American Medical Association. He will take over his new duties on January 1, 1958.

Dr. Blasingame will leave his private practice in Wharton, which he has carried on in the same location for 20 years, and will move his family to Chicago, where the AMA headquarters office is located, as soon as possible. Dr. Blasingame who is 50, has been active in medical affairs at both the state and national level, for many years. When the AMA House of Delegates elected him a member of the Board of Trustees in 1949 he was one of the youngest physicians ever chosen. Since then he has held many important AMA committee appointments. He served as president of the Texas State Medical Association in 1955. Teaching and medical education have always been close to his heart. After graduating from the University of Texas Medical School at Galveston in 1928, he spent three years as a teacher on the medical school staff. Since then he has maintained a teaching affiliation with the University of Texas.

Dr. Blasingame has long been active in civic affairs not only in his home town but throughout Texas. He is president of Blue Cross-Blue Shield

Plans of Texas; he is chairman of the Board of Trustees of Wharton County College and he is also chairman of the medical advisory board of Sears, Roebuck Foundation, which encourages young doctors to create new medical facilities where they are needed.

Dr. Edwin S. Hamilton, Kankakee, Illinois, Chairman, AMA Board of Trustees said that "the 164,000 members of the American Medical Association are fortunate in obtaining the services of Dr. Blasingame. He is young, highly experienced, and he is making the change at a great sacrifice to himself." Dr. Hamilton, in announcing the appointment, said that "Dr. Blasingame is dedicated to the principles of good medical care for all of the American people. He possesses all the essentials of leadership plus knowledge, imagination and sound thinking. His work on behalf of medicine through the years has shown that he has the courage and initiative to shoulder responsibility."

Dr. Lull, in his new job, will relieve the President of the Association of many of the burdens of this office, which have become especially heavy in the last few years. Dr. Lull, who is 70, joined the AMA staff after serving 34 years in the United States Army. His last position before retirement was deputy surgeon general of the Army.

Dr. Lull at present resides in Chicago. He is a member of the International College of Surgeons, the American College of Surgeons, and the American College of Physicians.

RADIOISOTOPES / Cargill

atom with additional neutrons so that the nucleus becomes unstable, disintegrates, and in the process of disintegration gives off penetrating radiation. Two things are necessary to accomplish this. First, a potentially explosive element must be implanted in the cancer. Second, a source of neutrons must be available. It is the lack of the second which has prevented adequate exploration of this hypothesis. Nuclear reactors are necessary to produce neutrons having the physical characteristics needed, and re-

actors being very expensive are rarely available for medical purposes. The reactor at Brookhaven National Laboratory has been used to produce neutron bombardment of brain tumors impregnated with boron, and the early results have been so promising that a special reactor for medical purposes is being designed.

The proposed research reactor for the Georgia Institute of Technology is unique in that complete medical facilities are incorporated into the original design. When this reactor is completed a formidable new weapon will be afforded to physicians in their fight against disease.

PERICARDIAL BIOPSY

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PERICARDIAL BIOPSY was first employed by the author in 1951 on a patient who had recurrent pericarditis. This first case in which the procedure was used was reported in 1952;¹ a subsequent report covering 16 operations was published in 1956.² Since 1951 there have been 26 cases in which pericardial biopsy has been used at the Cleveland Clinic.

Formerly, unexplained pericarditis was thought to be invariably tuberculous in nature, and it seems quite likely that on the basis of this presumption many patients in the past were given the label of "tuberculous pericarditis" and were started on an extended course of therapy. Specific diagnosis perhaps was not too important then, since treatment of the tuberculous process and of the nonspecific process alike was based on prolonged rest and observation. Now, however, since the development of antibiotics and antimicrobial therapy, it is mandatory that an exact diagnosis be made if it is at all possible, as our experience shows that pericarditis can have many forms from a variety of specific etiologies, not all of which are known at this time. The most common form of pericarditis that the author encounters still is of unknown etiology and probably is the most significant of all types.

Operation

Objective. The operation for pericardial biopsy has two objectives: (1) To obtain tissue for histopathologic and bacteriologic examination, and (2) to create a window through which effusion can drain into the adjacent pleural space.

Technique. The operation itself is a simple procedure and can be performed in a standard operating room on a patient who is gravely ill. Since the diagnosis of chronic pericarditis usually is made in a patient already hospitalized, the operative procedure does not appreciably increase the length of his hospital stay.

Pentobarbital sodium is administered intravenously to the patient immediately prior to induction of anesthesia. After the barbiturate has been given,

A review of the surgical technique of pericardial biopsy with a discussion of results in twenty-six cases.

cocaine (four per cent) is topically applied to the pharynx, vocal cords, and trachea. After cocaineization has been effected an endotracheal tube is inserted and positive-pressure oxygen is applied. Thiopental sodium may be given in very small doses to maintain the lightest possible plane of anesthesia. A chest-wall block then is performed over the selected operative site, using procaine (one per cent) as the preferred blocking agent.

The left pleural space is entered through a small intercostal anterior incision over the left fourth or fifth interspace. No ribs are cut or removed, as adequate exposure is obtained by using a baby rib spreader. The underlying lung may be kept fully expanded at all times by positive-pressure oxygen. After preliminary dissection of the overlying fat pad, the anterior surface of the pericardium is exposed and the biopsy site is selected. At the site of biopsy the pericardium may be raised by using a single traction suture. If fluid is present, needle aspiration is used to remove a specimen for bacteriologic and cytologic study. If cardiac tamponade has occurred it will be promptly relieved as the fluid is evacuated by decompression. The biopsy is completed by excision and removal of a circular disc of pericardium. The specimen then may be divided: a portion to be used for histopathologic study, the remainder to be placed in a tube for sterile culture for bacteriologic examination. No effort is made to close the pericardial opening or window, for if fluid is present it is advantageous to allow it free access to the adjacent pleural space, from which it may be drained to the exterior by closed waterseal suction.

After biopsy, a catheter drain is inserted through a stab wound in the midaxillary line and is connected to waterseal suction drainage; then closure

of the thoracotomy is easily performed by the use of pericostal catgut sutures.

Postoperative care. Since the incision is small, the patient usually has little incisional discomfort. The thoracotomy tube may be removed on the fifth day, and if necessary, any subsequent pleural effusion may be drawn off by needle aspiration.

Results

Twenty-six patients have undergone pericardial biopsy at the Cleveland Clinic Hospital. There have been no operative fatalities or hospital deaths in this series, although several of the patients later died of their disease. Individual cultures of the pericardial

tissue were made of all the patients. Cultures from only two patients yielded tubercle bacilli, but there was no histopathologic evidence of the disease in either patient; both were immediately improved by antimicrobial therapy. From a third patient the pericardial fluid gave a sterile culture, but the tissue culture yielded a pure strain of *Streptococcus viridans*; the patient recovered after prolonged penicillin therapy. Biopsy specimens revealed chronic hemorrhagic pericarditis in 10 patients. Cultures of the fluid and the pericardial tissue were sterile and histopathologic examination showed only nonspecific inflammation.

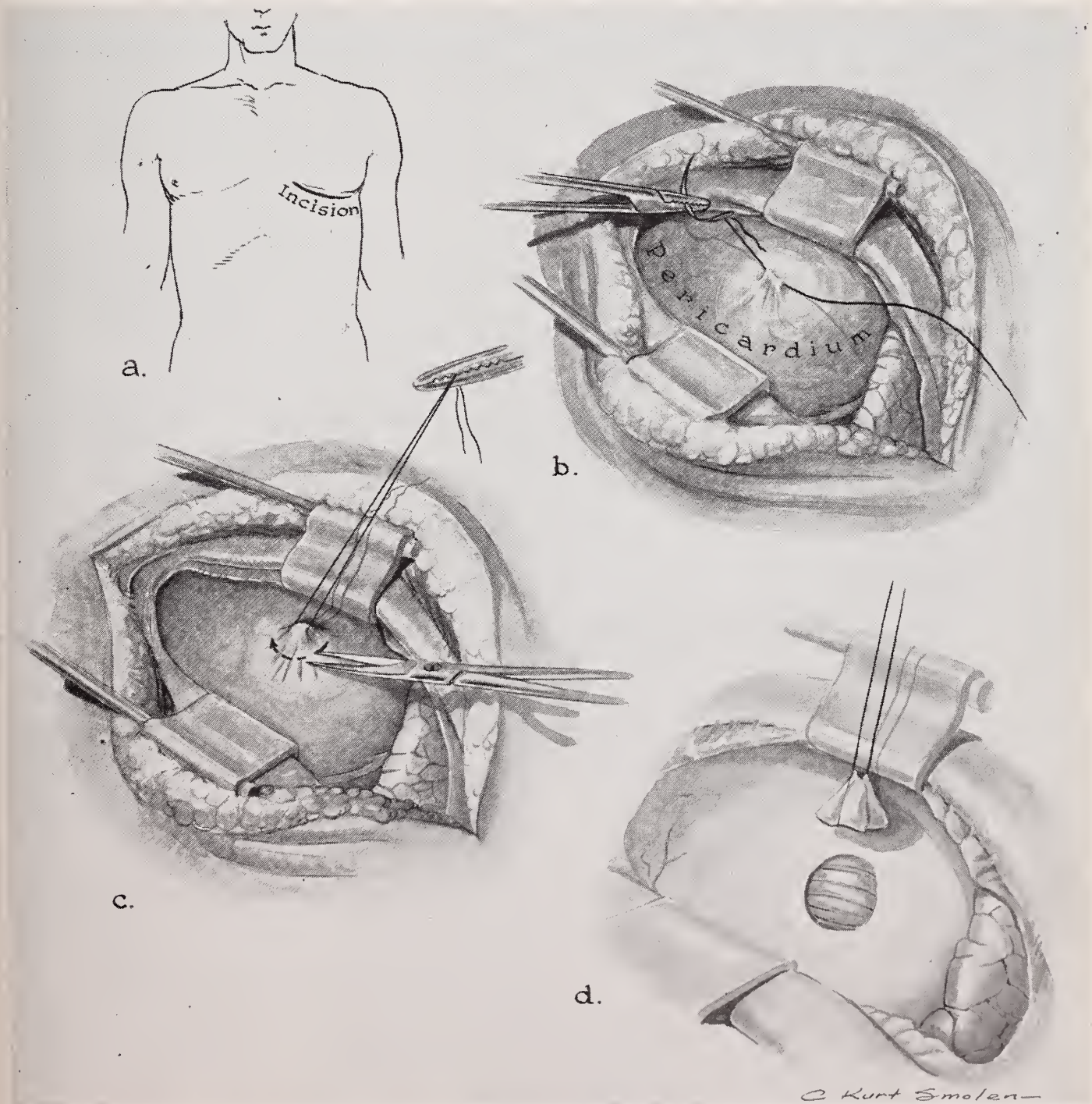


Figure 1: Technique of pericardial biopsy and intercostal incision, usually through the left fourth or fifth interspace, as shown in a. A traction suture is used to elevate the pericordium, as shown in b, and the biopsy specimen is removed by scissor or knife dissection, as shown in c, d. The specimen is divided under sterile conditions and one portion is placed in a sterile container for appropriate bacteriologic study, the other portion is used for histopathologic examination.

Four patients had massive pericardial effusion, in three of whom it had been caused by intrapericardial metastasis from malignant tumors of the mediastinum or the lung; in the other patient the effusion had been provoked by intensive radiation therapy after removal of a malignant thymoma. One patient had a true chylopericardium without pleural effusion; this case has been reported previously by the author and his associate.³

Discussion

Pericarditis in its various forms is a more common disease than it was originally thought to be, but the diagnosis is not always apparent and frequently is difficult to prove. Hemorrhagic pericarditis is characterized by tremendous thickening of the pericardium and a characteristic deposit of shaggy exudate over the entire surface of the heart and interior of the sac. The etiology of this form still is not known, but it is thought to be provoked by an acute inflammatory process probably viral in origin. It is the author's belief that hemorrhagic pericarditis well may be the precursor of constrictive calcific pericarditis when the residual blood elements are not absorbed.⁴

In carefully selected cases of pericarditis, paracentesis may be helpful, but it has marked limitations. For example, failure to obtain fluid by needle aspiration does not exclude the possibility of the presence of fluid, nor does a sterile culture of pericardial fluid exclude the possibility that a specific organism is present within the inflamed pericardium.

There is an appreciable risk in using paracentesis, as internal bleeding or trauma can provoke serious cardiac arrhythmia in a patient who already is severely ill.

The creation of a pericardial window provides continuous drainage when effusion is present. There has been no evidence in 26 cases to suggest extension of infection into the adjacent pleural space by this form of open internal drainage. Careful observation during the past seven years has shown not one instance in which aggravation or dissemination of the pericarditis has followed surgical biopsy and creation of the pleural pericardial window.

Conclusion

Pericardial biopsy is a simple, useful, surgical procedure for selected cases of pericarditis. Since 1951 it has been performed on 26 patients at the Cleveland Clinic Hospital. The pericardial window has produced good results by draining effusion into the adjacent pleural space.

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T. H. STUBBS NAMED MENTAL HYGIENE CHIEF

TRAWICK H. STUBBS has been appointed director of the Mental Hygiene Division of the Georgia Department of Public Health. He is a former assistant director of the Rhode Island Department of Social Welfare.

A native of Savannah, Dr. Stubbs received his bachelor of science, master's and medical degrees from Emory University. He interned at the U. S. Marine Hospital at Baltimore, Md., and later earned a master of public health degree, cum laude, from the Harvard School of Public Health.

He has served as a regular corps officer with the U. S. Public Health Service, as assistant dean and associate professor of preventive medicine, Emory medical school, and as dean of the University of Missouri medical school.

Dr. Stubbs was associated for a year with the

United Auto Workers, CIO, Detroit, as medical director of the Health Institute. He was medical director of mental health for the Rhode Island Department of Social Welfare and had served as assistant director of the whole department just prior to his appointment here.

His work in Georgia will involve development of an intensive treatment program for the mentally ill through the general hospitals in the state. Governor Marvin Griffin recently appropriated \$75,000 per quarter to begin a screening and short term treatment program for the mentally ill of moderate means and to help relieve the patient load at Milledgeville hospital.

Dr. and Mrs. Stubbs have two children, Trawick Jr., 15, and Kathey, 12. Their home is 1287 Oakdale Road, N.E.

MECAMYLAMINE

in the Treatment of Hypertension

A critical appraisal of the effectiveness of a new orally administered, long-acting blocking agent in the treatment of hypertension. Complete and predictable intestinal absorption is achieved with this secondary amine.

E. W. DENNIS, M.D., R. V. FORD, M.D., J. H. MOYER, M.D.,
and R. L. HERSHBERGER, M.D., *Houston, Texas*

THE GANGLIONIC BLOCKING AGENTS appear to be the most potent agents available among oral hypotensive drugs for reducing the blood pressure in patients with severe hypertension. Hexamethonium and pentolinium have established the place of ganglionic blocking drugs, but these two compounds have also pointed out some of the untoward effects of ganglionic blockade. Because of the marked variability of absorption from the gastrointestinal tract, there have been prominent orthostatic effects as well as variability of blood pressure response. Concurrent administration of rauwolfia serves as somewhat of a stabilizer, but some patients continue to have considerable difficulty. Hexamethonium and pentolinium are both quarternary ammonium compounds and are incompletely absorbed from the intestinal tract.

Mecamylamine, a secondary amine, has recently been introduced as a long acting ganglionic blocking agent which is completely absorbed from the intestinal tract. It was believed that some of the difficulties inherent in the use of the quarternary ammonium compounds might thus be averted by this constant and predictable absorption.

This report includes 104 patients from the hypertensive clinics of Hermann, Jefferson Davis, and Veterans Hospitals in Houston, plus some private patients of the authors. All received mecamylamine¹ by mouth, predominantly on an outpatient basis. Control observations were made on at least four visits over a one month period and included a complete history and physical examination, supine and upright blood pressures, pulse rate, EKG, chest x-ray, urine, CBC, and in some instances more definitive evaluation of renal function.

¹From the Department of Medicine, Baylor University College of Medicine, Houston, Texas; Cardiac Clinic, Jefferson Davis Hospital; Dept. of Medicine, Veterans Hospital, Houston, Texas.

²Supplied as Inversine by Merck Sharpe and Dohme, West Point, Pa.

In order to determine the blood pressure response, side effects, drug dosage and clinical response to therapy with mecamylamine alone as compared to mecamylamine used in combination with rauwolfia, patients have been divided into two groups. Group I consisted of twenty-four patients who received mecamylamine alone. A group of eighty patients received mecamylamine plus rauwolfia and constitute Group II. There are 35 of this latter group who received rauwolfia and mecamylamine for six months or more and have been used to compare the effect of time on continued therapy. The treatment period of these 35 patients has been subdivided into two consecutive periods of three months each.

The two major groups of patients in this study, that is the 24 who received mecamylamine alone and the 80 who received rauwolfia plus mecamylamine have been further subdivided into subgroups A and B on the basis of degree of elevation of diastolic blood pressure prior to therapy. Subgroup A consists of patients with controlled diastolic pressures more than 100 but less than 120 mm. Hg., and subgroup B consists of all patients with an average control diastolic pressure of over 120.

The 24 patients in Group I received mecamylamine only. The initial dose which rarely produced orthostatic hypotension of excessive degree was increased in a stepwise "titration" fashion until an optimal blood pressure response was obtained or until severe side effects limited further increase.

	7 A.M.	12 Noon	5 P.M.	10 P.M.
1st Week	2.5 mgm.		2.5 mgm.	
2nd Week	5 mgm.		5 mgm.	
4th Week	5 mgm.	5 mgm.	5 mgm.	5 mgm.
4th Week	5 mgm.	10 mgm.	5 mgm.	5 mgm.
5th Week	5 mgm.	10 mgm.	10 mgm.	5 mgm.
6th Week	5 mgm.	15 mgm.	10 mgm.	5 mgm.
7th Week	10 mgm.	15 mgm.	10 mgm.	5 mgm.

Table 1: Method of dose titration of mecamylamine.

The drug was given after meals. The guides to the weekly change in dosage were upright blood pressure and clinical manifestations of excessive hypotension.

The patients in Group II received reserpine (one mgm. daily) in divided doses, or alseroxylon (four mgm. daily) for at least two months before adding mecamlamine. The dose was titrated by the upright blood pressure in a manner similar to that described for mecamlamine alone.

Results

Of those with less severe disease, (control diastolic under 120) who received mecamlamine alone for four months, 60 per cent were responsive to therapy, i.e. obtained a reduction in average mean blood pressure of 20 mm. Hg. or more upright, forty per cent became normotensive. There was a response rate of 71 per cent (upright) in patients with more severe disease who received mecamlamine alone. Twenty-nine per cent became normotensive.

	No. Pts.	Response	Normal
Mecamlamine			
100-120	10	60%	40%
Above 120	14	71%	29%
Rauwolfia-			
Mecamlamine			
100-120	15	80%	33%
Above 120	65	91%	38%

Table 2: Treatment of hypertension.

The response rate was slightly higher in the group receiving rauwolfia plus mecamlamine. In the patients with less severe disease (subgroup IIB) 80 per cent became responsive and 33 per cent normotensive in the upright position. Patients with more severe disease who received rauwolfia plus mecamlamine showed a 97 per cent response rate and 30 per cent became normotensive. The severity of the disease therefore did not alter the response rate in that those with more severe disease actually tended to show a slightly greater response rate.

It has been possible to follow 35 of the 80 patients receiving rauwolfia plus mecamlamine for two treatment periods of at least three months each. More effective reduction was obtained during the second period, reflecting the establishment of a more

	I	Response II
Control 100-120	67%	83%
Normal	17%	67%
Control Above 120	86%	97%
Normal	31%	55%

Table 3: Rauwolfia-mecamlamine serial study on 35 patients.

individualized and effective dosage schedule for each patient.

The major side effects of mecamlamine alone and mecamlamine plus rauwolfia are qualitatively similar although quantitative differences exist.

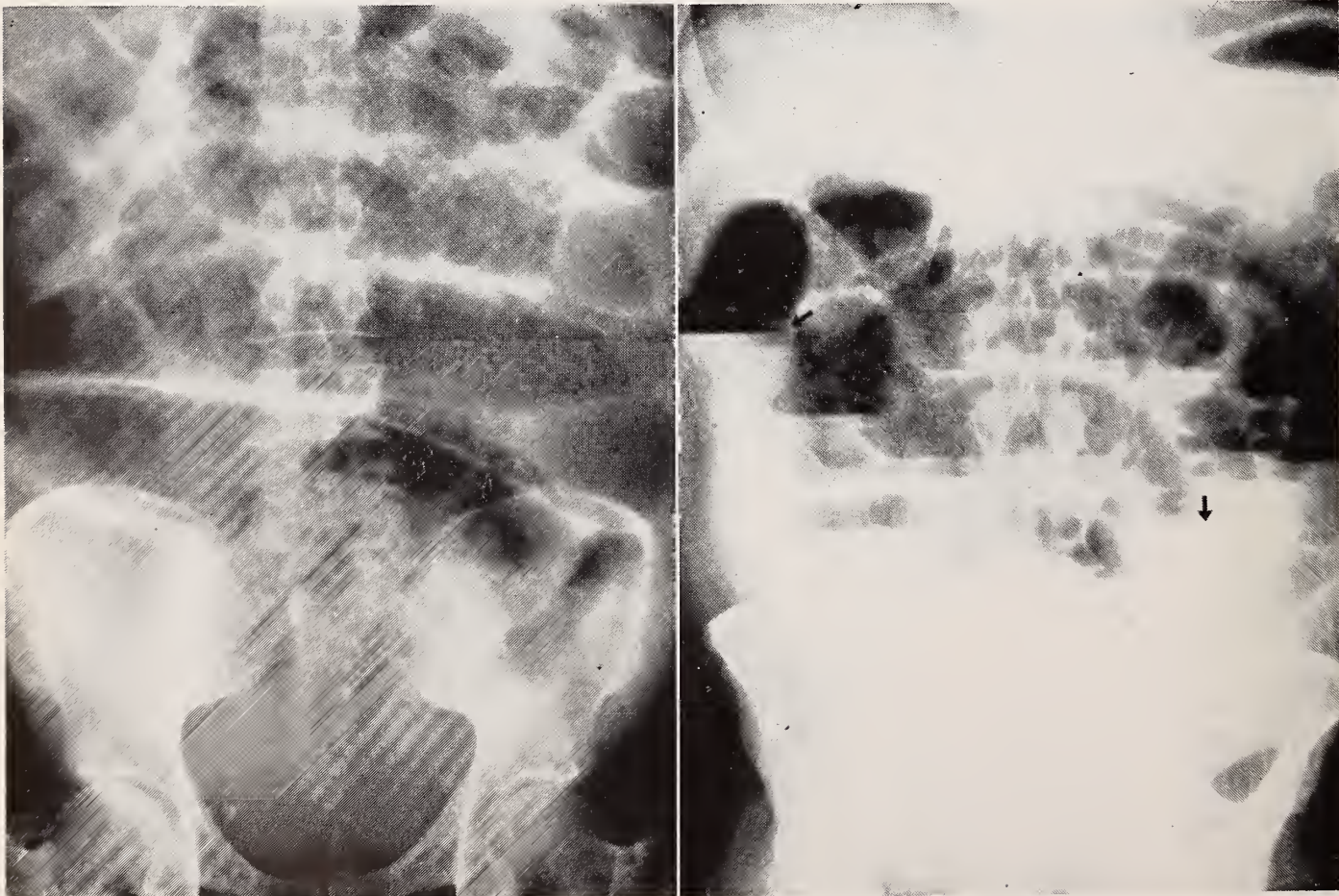


Figure 1: Flat plates of the abdomen showing a dynamic ileus following Inversine therapy.

	Mecamylamine Alone	Rauwolfia
No. Pts.	24	81
Bradycardia	12%	44%
Constipation	79	67
Weakness	67	43
Dizziness	46	41
Dry Mouth	67	43

Table 4: Comparative side effects.

Bradycardia, prominent with mecamylamine and rauwolfia, is a rauwolfia effect. Constipation was more severe with mecamylamine although the incidence was comparable. It could often be relieved by prostigmine, 10 mgm. TID. Irritant cathartics such as cascara (.65 grams at bed time) was often necessary in addition to this. Frank ileus has occurred in several of these patients necessitating their admission to the hospital. Dizziness, blurring of vision, and other orthostatic effects are common but less severe than was seen with other ganglionic blocking agents. Dryness of the mouth has been a prominent complaint resulting in anorexia in some patients.

In both groups of patients symptoms appeared better controlled with more prolonged therapy. Symptomatology such as angina, congestive failure, headache, when present was improved in one-fourth and renal studies showed improvement in a fourth also.

Mecamylamine is a ganglionic blocking agent which apparently blocks both sympathetic and parasympathetic ganglia. Therefore, when doses adequate to block the sympathetic ganglia are given, one can also expect the effects of parasympathetic blockade. Under these circumstances, responses due to parasympathetic blockade are considered side effects since it is only sympathetic blockade which is desired. The symptoms produced by parasympathetic blockade are expected and are the normal response. One therefore is not surprised to encounter dry mouth, constipation, diminished intestinal motility and the like with pentolinium, hexamethonium, or mecamylamine.

The outstanding attribute of mecamylamine is that it is equally effective orally and parenterally.

Pat.	Cont. B Pressure		BP Max. Resp.	
	Up.	D	S	D
T.R.	(O)	192	128	112
	(P)	190	120	118
K.C.	(O)	218	148	138
	(P)	238	150	146
J.M.	(O)	190	115	120
	(P)	188	112	116
L.T.	(O)	225	134	128
	(P)	256	137	160
	(O) Orally		(P) Parenterally	

Table 5: Blood pressure response comparing oral and parenteral mecamylamine.

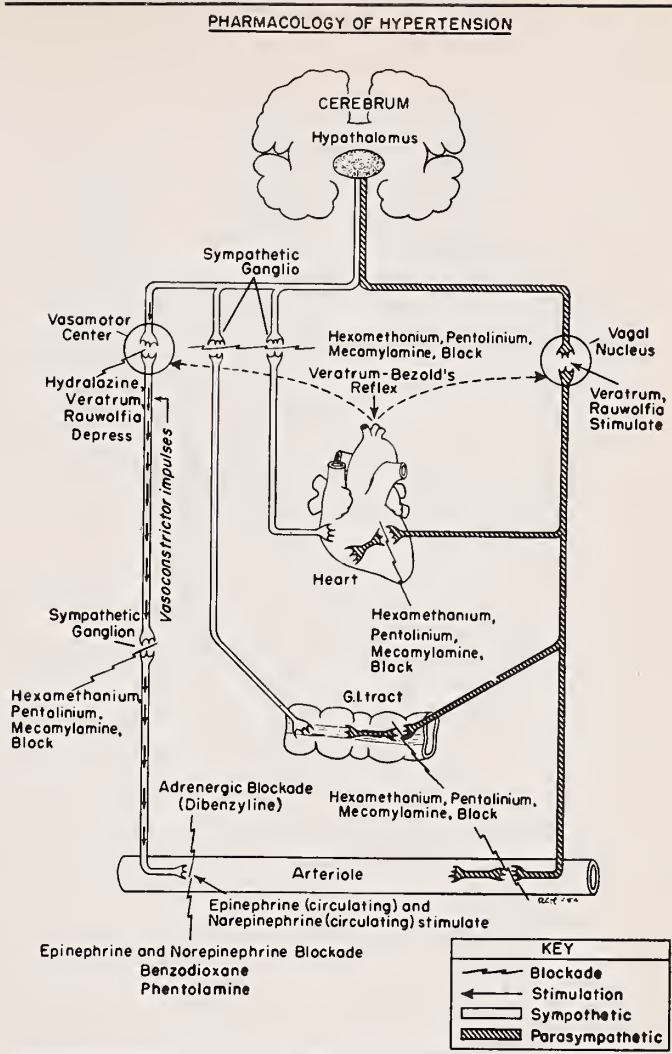


Figure 2: Schematic diagram showing points of action in autonomic nervous system of various antihypertensive agents.

In table five the response in the same patient to the same dose of mecamylamine orally and parenterally is shown for four patients. The similarity of the response is striking. A similar study was done averaging the response in 11 patients who received the same dose of mecamylamine by the two routes. This is summarized in Table 6 showing a comparable fall, with also similar onset of action and duration of effect.

	Control	Lowest	Mean
IM	181/120	118/82	132 to 94
Oral	186/119	122/81	141 to 95
	Duration	Onset	
IM	21 hours	46 min.	
Oral	22 hours	37 min.	

Table 6: Mecamylamine-blood pressure response, oral and parenteral, in 11 patients.

Renal function has been studied in eight patients receiving mecamylamine. Renal hemodynamics were not markedly altered if the blood pressure was not reduced excessively. Figure 3 shows the minimal reduction in renal function with mild reduction in blood pressure. Figure 4 shows the rather precipitous fall in glomerular filtration rate and renal plasma flow with excessive orthostatic reduction in the

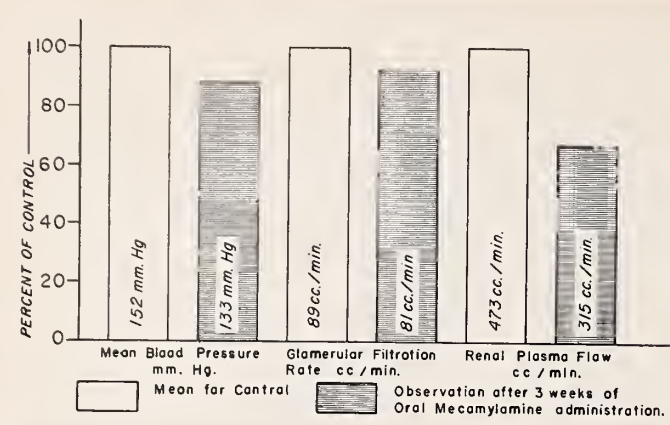


Figure 3: Effect of longterm mecamlamine therapy on renal function and blood pressure in supine position in man.

blood pressure. This will occur with practically all agents which reduce the blood pressure.

In comparison with the other ganglionic blocking agents hexamethonium and pentolinium, we have obtained more satisfactory control of hypertension with mecamlamine and rauwolfia. It is our opinion that mecamlamine may be used more advantageously in combination with rauwolfia. It permits a lower and more pleasant dose of mecamlamine and

	Mecaml.	Rauwolfia	
No. Pts.	50	75	75
Responsive	92%	76%	79%
Normal	24	37	33
Av. Dose/Day	17 mg.	2307 mg.	341 mg.

facilitates a smooth hypotensive response. A typical response curve shown in Figure 5 shows the added stability of blood pressure reduction brought on by the rauwolfia. Usually, unless the hypertension is fulminating and severe, the rauwolfia is given alone for two to three months before the mecamlamine is added.

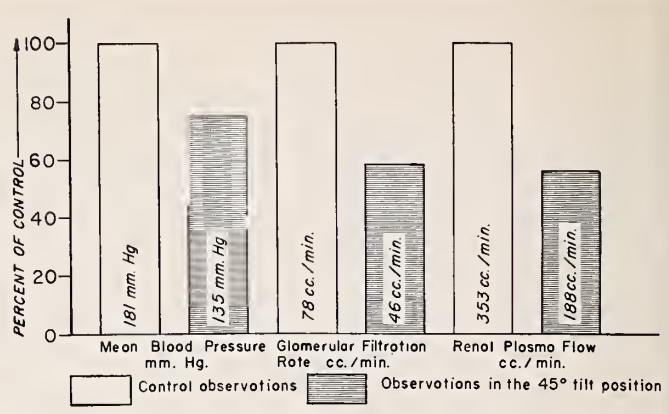
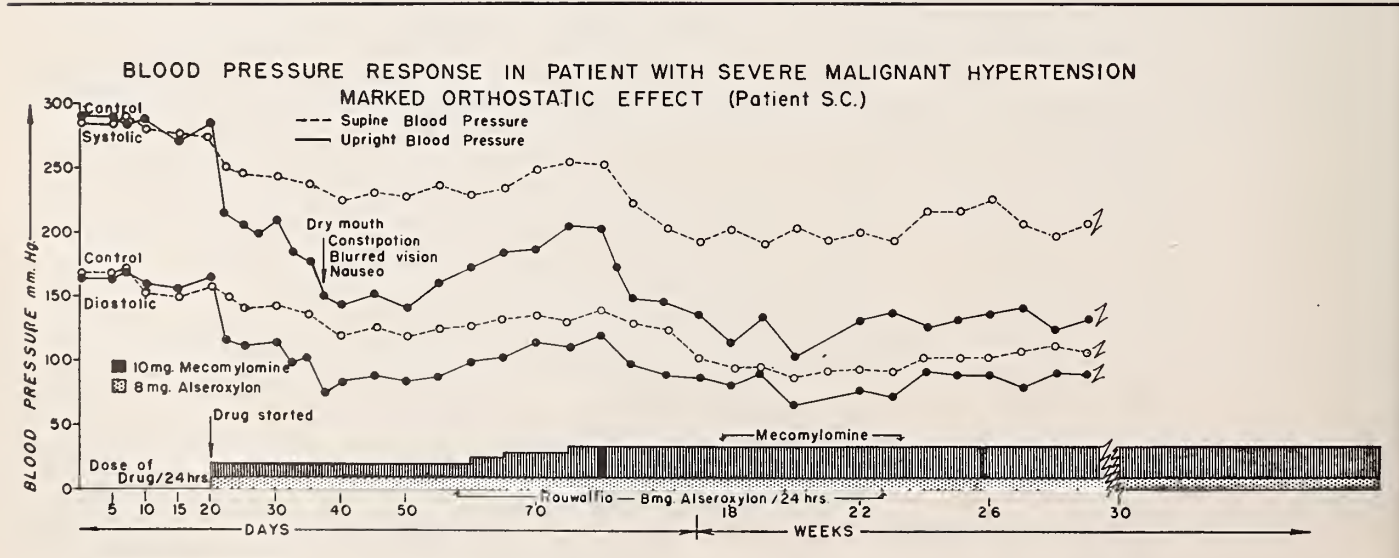


Figure 4: Effect of upright position on renal function and blood pressure as compared to control supine function in patient obtaining marked orthostatic effect on blood pressure. After one month of mecamlamine therapy.

Summary

- (1) Results obtained in the treatment of hypertension with mecamlamine, a ganglionic blocking agent, which is completely absorbed from the intestinal tract have been reviewed. These patients were treated on an ambulatory basis.
- (2) The drug is an effective agent for reducing the blood pressure in patients with severe hypertension. Because of its complete oral absorption it is more predictable from day to day and is easier to titrate since the oral and parenteral route of administration can be used interchangeably, employing the same dose.
- (3) The side effects with mecamlamine are similar both qualitatively and quantitatively to those observed with other available ganglionic blocking agents and the initial effect on reducing intestinal peristalsis may be more marked than with other blocking agents.
- (4) The pharmacology and specific clinical problems relative to the use of this drug for the treatment of hypertension have been reviewed.



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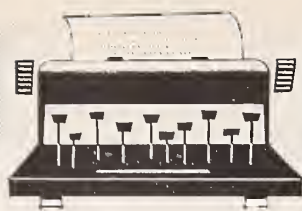
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editorials

RADIOACTIVE FALL-OUT AND THE PHYSICIAN

THE TWO-FACED JANUS of nuclear energy looks from one side upon death, destruction, and the awesome prospect of genetic changes affecting future generations; from the other, upon the pleasant vista of the prolongation of life, the alleviation of suffering, and an understanding of the nature of disease. This dichotomy was anticipated by the scientists who created the first self-sustaining chain reaction under Stagg Field in 1942 and is appreciated by all who are responsible for the control of nuclear energy today. In an address before the General Assembly of the United Nations on December 8, 1953, President Eisenhower declared:

"... the United States pledges before you—and therefore before the world—its determination to help solve the fearful atomic dilemma—to devote its entire heart and mind to find the way by which the miraculous inventiveness of man shall not be dedicated to his death, but consecrated to his life."

Physicians are concerned with this dilemma not only as guardians of health but also as trusted advisors and intelligent, well-informed members of their communities. They should be prepared for the question: "Do the benefits afforded by the widespread utilization of nuclear energy outweigh the inherent hazards?" This is analogous to the old problem—"What good is a newborn baby?", the answer to both being that it is too early to tell.

The current debate over the advisability of testing nuclear weapons need not be extended to the pages of this journal. Rightly or wrongly, incredible amounts of energy are being released into the atmosphere at periodic intervals just as in previous years the explosion of innumerable firecrackers by irresponsible small boys could be anticipated every

Fourth of July. The physician was prepared for the latter; he expected burns, tetanus, and blindness. What may he anticipate from a steadily increasing level of "background" radioactivity? Nothing, according to spokesmen for the Atomic Energy Commission; but other equally qualified scientists are fearful of an increased incidence of leukemia and other blood dyscrasias, of bone tumors, and of harmful genetic effects. Except through his representatives in Congress, the practicing physician has no control over the radioactive contamination of the environment, but he should be aware of the fact that his patients are being exposed constantly to increasing amounts of "natural" radiation. It has been proven that the biological effects of radiation are cumulative over the lifetime of the individual. These effects, resulting from ionization within cells, are the same from all sources of radiation—cosmic rays, radioactive fall-out from atomic bombs, radium, X-rays, etc. It therefore behooves the physician to restrict the exposure of his patients to the types of radiation which he can control.

The chief difficulty is that no one knows what to consider a "safe" level of radiation exposure. Somewhat arbitrarily the AEC has established the value of 300 milliroentgens total body irradiation per week as the maximum permissible dose of radiation and has based its calculations of the danger from radioactive fall-out on this figure. But what will be the effect of radiation from long-lived radioactive isotopes localized in specific tissues—strontium 90 in bone for example? Only time will tell, and one need only recall the radium watch dial painters of New Jersey who succumbed many years later of osteogenic sarcoma of the jaw, or the pioneer radiologists who have gradually lost their fingers to realize that the time may well be long.

One thing is certain. An accurate record of the amount of radiation exposure received by each individual patient should be maintained by every physician who administers any type of radiation—X-rays, radium, radioisotopes, etc. Ideally this record should be in the hands of the patient as he goes from doctor to doctor, so that every patient would have a continuing record of known radiation received during his lifetime.

Walter H. Cargill, M.D.

PREACH WHAT YOU PRACTICE

IN PAST YEARS physicians have been chided for a "negative, do-nothing" approach to proposals for health improvements. Physicians have been rebuked for a cold impersonal attitude toward patients. They have been blamed for the cost of medical care and have been reproached for the actions of a few

unethical medical men. The profession has striven to correct this conception and has concerned itself with renewed activity in the interest of the community. In eliminating the causes for public criticism, the profession has emphasized the "positive" and has put its house in order. But even this is not enough. The public must be informed repeatedly of the excellent job that doctors are doing. This amounts to *preaching what you practice*.

Preaching what you and your society practice is public relations. It is not merely getting credit for a job well done—it is letting the community know that the job is being done! Ultimate success will not thrive in a vacuum, and each society must tell its story of public service to the peoples it serves. Public service means doing the right thing in the interest of the community as the need arises—and then letting the people know you are doing it.

The newspapers, civic organizations, civic officials, and the whole community should have an understanding of your society, its function, purposes, and services. Let the public know of the society's scientific and business meetings. Service projects undertaken by the society gain public support and merit public approval. Projects by the Societies such as Emergency Call Systems, Grievance Committees, Indigent Medical Care, Immunization Programs, Disease Detection Drives, Citizenship Projects and other public services give valid evidence of the society's leading the community and thereby meeting its responsibility. By publicizing these activities your society wins the renewed confidence and added respect for its profession.

County Medical Societies are *urged* to tell their story to the public and to keep medicine in the public eye. The profession must realize the importance of the good will of the community and become a recognized entity in the community. Individual physicians can best do this through their society and its public service activities.

JUST A LITTLE CASE OF CYSTITIS

"JUST A LITTLE CASE OF CYSTITIS" may actually have already involved the kidney parenchyma before the bladder became infected. Pyelonephritis is an insidious, even symptomless disease, which gnaws away at the kidney reserve and may in a few days or over a period of several decades lead to serious or fatal consequences.

Pyelonephritis usually begins in the interstitial tissue, the tissue between the tubules, where the infecting organism is brought by the bloodstream or

through the lymphatics, sometimes by direct extension from the pelvis of the kidney. Until the infection is released into the tubule the urine may be *free of leukocytes* and even *urine cultures may be negative*.

The severity of the process may vary from a fulminating, necrotizing papillitis with oliguria or anuria to a low-grade, smoldering infection with no signs, symptoms, or laboratory findings.

The origin of the infection may be any infectious focus, and it is believed from experimental work that a slight interference with free urine flow is essential to permit the settling out of the bacteria in the kidney. It is not unlikely that many bacteria pass through the normal kidney daily without producing any pathological process.

The locus of the infection and the structure of the kidney combine to produce functional disturbances of fascinating variety. In most instances the glomerulus is protected because the flow of blood through it is free and rapid and also because it is divided from the interstitial infectious site by Bowman's capsule. Thus the proximal and distal convoluted tubules and the collecting ducts bear the brunt of the attack. In order to understand the pathological physiology of this disease one must bear in mind that (1) the blood NPN or BUN level is dependent upon glomerular function or "filtration;" (2) The proximal convoluted tubules reabsorb Na^+ and Cl^- and H_2O more or less in the same proportion as they are found in the plasma. It is here, too, that 85 per cent of the PSP dye is secreted and that sugar is reabsorbed; (3) The distal convoluted tubules adjust acid-base balance through the formation of ammonia and the exchange of hydrogen ions for excretion for Na^+ ions to be resorbed; (4) The collecting tubules are probably the site of action of the antidiuretic hormone where the urine is concentrated.

Since pyelonephritis attacks the convoluted tubules, particularly the distal ones and also the collecting ducts, the primary disorders consist of a loss of urine concentrating ability and disturbances in acid-base balance as well as electrolyte abnormalities. Since the damaged tubules cannot excrete ammonia and H^+ ions, Na^+ , K^+ , and Ca^+ must be excreted to combine with the negative ions eliminated in the urine. This produces a deficit of Na^+ , K^+ , and Ca^+ and leaves an excess of H^+ ions which results in acidosis. Patients may have profound acidosis and cation or positive ion depletion without any NPN elevation. Only after considerable Na^+ loss with resulting low blood volume does the filtration rate fall and bring about a rise in blood NPN. Pure tubular failure offers a fine therapeutic opportunity because all one needs to do to correct

the chemical abnormality is to make up the Na⁺, Ca⁺, and K⁺ loss by oral administration.

The typical case with chills, fever, costo-vertebral angle pain and pyuria is easy to diagnose but the low-grade smouldering infection without pyuria is difficult. A positive urine culture may come from contamination during catheterization so that a positive culture alone would be of little value. Some cases proven by needle biopsy and culture have been found to have negative urine cultures so that a negative culture does not rule out pyelonephritis.

Quantitative urine cultures help to eliminate the contaminants. Dilutions of urine enable the bacteriologist to determine whether there are 100, 1,000, 10,000, etc., colonies per ml. MacDonald and co-workers have found that 100,000 colonies per ml. signify infection in the urinary tract and not contamination.

Correction of anomalies which obstruct free urine flow is important in the prevention of pyelonephritis. Incomplete bladder emptying as in patients with cystoceles encourages infection. Once infection has occurred it should be treated vigorously with an appropriate antibiotic for two to three weeks to try to prevent a recurrence.

Many infections begin with either single catheterizations or use of an indwelling catheter. Collection of specimens for culture may be made as "clean caught" specimens as suggested by Murdaugh. The perineum is sponged with an antiseptic solution, a light gauze pack is placed at the vaginal orifice, and the specimen is caught at about the midpoint of voiding. The number of contaminated specimens obtained in this fashion is less than with catheterization.

Kass also found that with indwelling catheters, infection travels along the outside of the catheter, not the inside. Irrigation around the external urethral orifice and the catheter with an antiseptic solution every four hours almost completely prevents urinary infections.

Treatment must be prolonged to two to three weeks to prevent recurrences. With repeated infections, a culture should be obtained and sensitivities of the organisms determined so that the appropriate antibiotic may be employed. It must be remembered that sulfa-drug sensitivities and mandelic acid sensitivities are not reliable. Also the disc method cannot be trusted and it is necessary to use the tube method to obtain accurate results.

SBA LOANS TO PHYSICIANS

UNDER A RECENT policy change, the Small Business Administration can now make loans to physi-

cians, surgeons, and others engaged in professional services, according to James F. Hollingsworth, Regional Director of SBA in Atlanta. Previously SBA had not been permitted to make loans to professionals, since these were not considered as small business within the meaning of the Small Business Act.

With the new policy, the agency can make loans for the following purposes: (1) To finance construction, conversion, or expansion of hospitals, clinics, or offices to be used for professional services; (2) to finance the purchase of equipment, facilities, supplies, or materials; and (3) to meet other operational needs.

SBA does not make loans where capital is available on reasonable terms from banks or other private lending agencies. Applicants, therefore, are advised to have letters from two banks to the effect that the banks cannot supply the capital as needed. If the local bank cannot make the total loan, it is asked to participate in the loan with SBA. If the bank cannot participate, SBA may then make a direct loan.

To qualify for consideration for either a participation or a direct loan, the applicant must be considered a small business and must meet certain practical credit requirements. Since any firm employing fewer than 250 persons is considered *small*, applicants from the medical profession would not ordinarily be affected by the size provision.

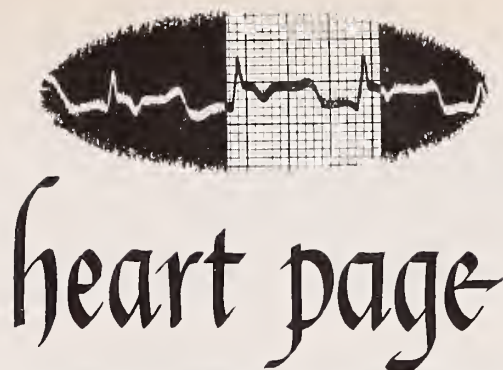
To be eligible for a loan, an applicant must be of good character, have the ability to operate his business successfully, and must have enough capital so that with loan assistance from SBA it will be possible for him to operate on a sound financial basis. His past earnings record and future prospects must indicate ability to repay the loan out of income.

The maximum amount of a direct SBA loan, or of SBA's part in a participation loan, is \$250,000.00, with a maturity limit of ten years. The interest rate cannot be more than six per cent, and may be less in the case of a participation loan, if the participating bank charges a lower rate.

It is suggested that any member of the medical profession who previously inquired about an SBA loan and was not encouraged to file an application, on the basis that he did not qualify as a "small business," should contact SBA and ask that his application be reconsidered. The regional office of SBA is located at 90 Fairlie Street, N. W., Atlanta 3, Georgia. SBA personnel at this office will be happy to give advice and assistance in the preparation of an application. No appointment is necessary. Copies of applications and a copy of a pamphlet, "SBA Business Loan," may be gotten from the regional office on written request.

HEART DISEASE IN GENERAL PRACTICE

W. G. ELLIOTT, M.D., *Cuthbert, Ga.*



HEART DISEASE in some form comprises a large part of the practice of every physician. We physicians who do general practice, or the family physician, treat all types of heart disease. It is our duty and obligation to familiarize ourselves with the various aspects of the diagnosis and treatment of heart disease.

Most often we are the one who first sees the child with congenital heart disease and we should be able to recognize the condition and to handle it properly until such time when the cardiac surgeon can take over the situation. We should then be able to care for the child after the surgery has been accomplished. Family guidance and counseling plays a large part in this after treatment.

The family physician is usually the first one to see the child or young person with rheumatic fever, and he should be able to take care of this case also. It is the duty of the family doctor to play the leading role in the campaign to stop rheumatic fever. The cardiologist is most important, and the generalist needs him for consultation and consolation, but the bulk of the burden should and does fall on the family physician in rheumatic fever cases.

The cases of bacterial endocarditis are treated largely by the family physician. He may often need help in getting cultures and advice concerning treatment, but the general treatment falls in his category.

The generalist is most often the one who sees the adult with hypertension, hypertensive cardiovascular disease, and all of its complications. It is largely through his treatment and efforts that the patient can make the proper adjustments to live longer with his condition and lead a more comfortable and useful life.

He is also the one to see and to take care of the patient with an acute cardiac condition, a coronary thrombosis, acute congestive heart failure, cerebral vascular accidents, and other such conditions. His efficiency and ability to deal with the patient as a whole means a great deal toward the well being and

ultimate outcome of these patients.

The man in general work owes much to the cardiologist, the research man, the cardiac surgeon, and other specialized groups for their aid in giving him the means of knowing how to handle many of these cardiac cases and in giving encouragement for many patients that heretofore have been hopeless ones.

The man in general practice need not use every new technique of treatment or every new drug that is recommended for treating patients with heart disease, but he should keep abreast of the times and should have a knowledge of the new things which have been proven to be useful by proper research and ground work. Neither should he be last to use something that has been proven to be of benefit to these cardiac cripples.

The man in general practice is in the unique position of being able to treat the whole patient, and for this reason he can effect a cure for the cardiac better than anyone else. He should know his limitations and should call in or send the patient to the specialist when his condition warrants it. When surgery is indicated he should not wait until it is too late before referring the case for study and for preparation for surgery. The benefit and wellbeing of the individual patient should be the primary aim of every general practitioner at all times.

The physician in general practice can accomplish much good by joining and supporting the State Heart Association and can gain much good practical knowledge by attending the annual scientific session. The lecturers on the programs are usually well-known national figures, and through these programs the general practitioner can prepare himself to render more efficient service to his patients.

We general practitioners should always bear in mind that a most important factor, in the treatment of heart disease is early diagnosis. Diagnosis may be made early in the course of heart disease by the proper evaluation of a single symptom or sign, or by

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

THE MONTH IN WASHINGTON

Washington, D. C.—In the last few years interest has built up in the problems of the older people—how they are to get their bills paid, how to spend their time constructively, what chronic medical conditions are causing them the most trouble. Innumerable national and local conferences have searched for ways to make life more satisfying and healthy for people entering old age, and committees are at work on the problem in thousands of communities.

In this favorable climate, when every device that might help the older citizens is being examined, a scheme is being revived that met with no success at all when first proposed more than six years ago. It is a plan for government-paid hospitalization under the Old Age and Survivors' Insurance system. Here is the argument that is made for it:

People in old age generally have less income than when they were younger, but at the same time they require more medical attention and hospital care. Neither voluntary nor commercial health insurance has been able to offer these people the protection they need. The only solution, sponsors of the plan say, is to get the federal government into the picture.

Opponents of the idea agree that older people are sick more often and generally don't have much money, but they disagree violently with the other arguments. They point out that slowly but surely insurance coverage is being extended to older people at a price they can afford to pay. Most important, "hospitalization-at-65" critics maintain that a system like this is in effect national compulsory health insurance under Social Security.

Early this year Reps. Emanuel Celler (D., N.Y.) and John Dingell (D., Mich.) introduced bills on this subject. They would allow 60 days a year free hospitalization for OASI-covered men 65 and over and for women 62 and over. Rep. Kenneth A. Roberts (D., Ala.) offered a similar bill.

Just before the session ended two developments occurred that present evidence that the proponents of this system of hospitalization are getting ready to make a real fight for it next year.

First, Rep. Aime J. Forand (D., R.I.) presented a bill that would make extensive liberalizations in

the social security program, including creation of a hospitalization that would give free surgical service to the aged program. Some national labor leaders immediately pledged their support to this bill, a not unexpected move as the AFL-CIO is officially behind the general idea.

Then Senator Richard L. Neuberger (D., Oregon) made it plain that he, too, wanted the old people to have free in-hospital medical care. The senator said he hadn't firmed up his thoughts, but that he believed the best approach would be something like the Military Dependent Medical Care program (Medicare), making use of Blue Cross or other non-profit groups. He estimates that a one per cent increase in payroll taxes for both employer and employee would meet the extra costs.

Mr. Forand, on the other hand, is specific. He would make all persons receiving OASI retirement benefits eligible and also surviving widows and children, but would not include persons receiving OASI disability payments. He would broaden the time period by allowing 120 days of hospital or nursing home care each year, with hospital stays limited to 60 days.

The Forand measure also has a provision, not contained in most earlier bills, for OASI also to pay for in-hospital surgical services certified as necessary by the physician.

Mr. Forand would take no chance of running out of money. He would levy social security payroll taxes on all income up to \$6,000 (present limit \$4,200), and also increase the tax rate a half per cent for employer and employee alike, and three-quarters of one per cent for the self-employed.

It is almost certain that these and other similar suggestions will receive serious consideration by Congress next year, with passage of a bill much more likely than in 1951 when President Truman and Oscar Ewing first proposed the idea.

NOTES:

When Congress returns January 7, one of the measures waiting its attention will be a bill to control union welfare funds through registration and publicity. (Most funds involve medical-hospital benefits.)

HEART DISEASE / Elliott

a single well-placed question. Symptomatology will always retain its major importance in medicine because it is the keystone in the arch of diagnosis. The symptoms, to quote Sir John Parkinson, "from the first contact between the patient and the doctor. It is the voice of nature, and when a patient complains, he enters our world and we recognize a

human need." We should always keep this in mind and strive to render such service as will enable us to make this early diagnosis.

Let us make ourselves aware of advances in cardiology and strive to learn the proper use of them. Through an early diagnosis and a knowledge of the better types of treatment, we, as general practitioners, can render an outstanding service to mankind.

BOOKS RECEIVED

Northrup, Eric, **SCIENCE LOOKS AT SMOKING**, Coward-McCann, Inc., New York, 1957, 190 pp., \$3.00.

Woodhall, Barnes, M.D., and Beebe, Gilbert W., Ph.D. (Editors), **A FOLLOW-UP STUDY OF 3,656 WORLD WAR II INJURIES**, U.S. Government Printing Office, Washington, D. C., 638 pp.

Wolstenholme, G. E. W., O.B.E., and O'Conner, Cecilea M., B.S. (Editors), **CIBA FOUNDATION COLLOQUIA ON AGING (Volume 3)—METHODODOLOGY ON AGING**, Little, Brown and Co., Boston, 1957, 196 pp., \$6.50.

Weiss, Edward, M.D., and English, O. Spurgeon, **PSYCHOSOMATIC MEDICINE, A Clinical Study of Psychophysiologic Reactions**, W. B. Saunders Company, Philadelphia, 1957, 557 pp., \$10.50.

Wallerstein, Robert S. & Associates, **HOSPITAL TREATMENT OF ALCOHOLISM**, Basic Books, Inc., New York, 1957, 180 pp., \$5.00.

Christopher, Frederick, M.D., **ONE SURGEON'S PRACTICE**, W. B. Saunders Company, Philadelphia, 1957, 151 pp., \$4.00.

Mulholland, John H., M.D.; Ellison, Edwin H., M.D.; and Friesen, Stanley R., M.D., **CURRENT SURGICAL MANAGEMENT**, W. B. Saunders Company, Philadelphia, 1957, 494 pp., \$10.00.

King, Edward L., **OCCIPITO POSTERIOR POSITIONS**, Charles C. Thomas, Springfield, Ill., 1957, 99 pp., \$3.75.

Robertson, E. Graeme, **PNEUMOENCEPHALOGRAPHY**, Charles C. Thomas, Springfield, Ill., 1957, 463 pp., \$14.00.

Windle, William F. (Editor), **NEW RESEARCH TECHNIQUES OF NEUROANATOMY**, Charles C. Thomas, Springfield, Ill., 78 pp., \$4.75.

REVIEWS

Hilliard, Marion, M.D., **A WOMAN DOCTOR LOOKS AT LOVE AND LIFE**, Doubleday and Company, Inc., Garden City, New York, 1957, 181 pp.

Dr. Hilliard has written a delightful and informative book for and about women. It is written in lay language, with a chapter devoted to each phase of a female's life and the special problems pertaining thereto, from adolescence through old age. Her style is free and easy, and there are many bits of humor scattered throughout the vast amount of practical wisdom. It answers most of the asked and unasked questions in any female patient's mind and even has one chapter devoted to husbands. There is just enough of that totally illogical female logic to break the monotony, and unless your practice is limited to male geriatrics, I highly recommend a copy for your waiting room. The chapter of most interest to a patient could be read during the average wait of the visit to the doctor and would, I'm sure, save time lost in dealing with the fears, phobias, and mis-information that many patients have.

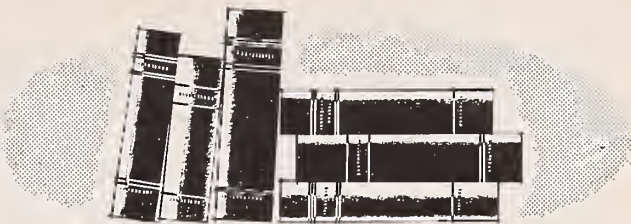
Vernelle Fox, M.D.

Sollman, Torald, M.D., **A MANUAL OF PHARMACOLOGY**, Eighth Edition, W. B. Saunders Company, 1,536 pp., \$20.00.

The latest edition of Sollman's Manual of Pharmacology offers the same compendious treatment of pharmacology as in previous editions. The organization and format have been unchanged and it would appear that revisions have been limited merely to including new information.

As with previous editions this book should be considered primarily as a reference manual, particularly

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.



physician's bookshelf

for the research pharmacologist. As a textbook for medical students or even as a reference book for practicing physician it is poorly organized and is too detailed in the coverage of the actions of drugs. When considered from a pedagogical point of view, the complete absence of illustrative material (such as graphs, schematic diagrams, etc.) is a serious omission. Equally disturbing to the teacher and presumably to a student using this book is the organization. For instance, there are no discrete chapter headings, one major subject merging with another on the same page. The classification of drugs, while following a discernable over-all pattern, is arbitrary. Mephenesin, a spinal cord depressant, is discussed immediately after cholinergic blocking agents although it has no such proven action in itself. Descriptions of hydralazine (a hypotensive drug of uncertain mechanism of action) and phentolamine (Regitine) and tolazoline (Priscoline), both adrenergic blocking drugs, are presented between the discussions of cholinergic blocking drugs and cholinergic agents. Another example of poor organization can be found under the heading "Sympatholytic Drugs." In this section the author describes the properties of dibenamine and derivatives, dioxan derivatives and "mistletoe." The former are indeed adrenergic blocking drugs but "mistletoe" is not. Furthermore, no cross reference is given to the pages in which the imidazoline adrenergic blocking drugs (phentolamine and priscoline) are discussed. Azapetine, (Ilidar), another adrenergic blocking agent which has been the subject of a number of pharmacological studies is not mentioned in the book. Thus, a reader interested in adrenergic blocking drugs must use the index to find each particular drug of this class. Furthermore, one lacking a detailed knowledge of pharmacology might obtain the erroneous impression that mephenesin is a cholinergic blocking drug and that "mistletoe" is of the class of drugs which block the sympathetic nervous system.

In addition to the arbitrary classification, there are a number of errors in interpretation that appeared on a random reading of various sections of the book. For instance, it is stated that the digitalis glycosides cause a prolongation of cardiac systole in spite of clinical and animal experimental studies which demonstrate a shorter, but stronger, contraction of myocardium under the influence of cardiac glycosides. Another example of faulty interpretation of evidence is the allegation that the hypotensive action of veratrum alkaloids "consists

chiefly of a general vasomotor inhibition by a central action supported by a reflex bradycardia and inhibitory vasomotor reflexes . . ." Pharmacological studies in the past five years have demonstrated that such veratrum alkaloids as are used clinically (Veriloid, protoveratrine) lower blood pressure in animals entirely by reflex mechanisms and in fact stimulate, not depress, the vasomotor center.

The coverage of many topics is much too detailed for a useful and effective textbook. The author has mitigated to some extent this emphasis on detail by the use of two type sizes. The text in "ordinary type" presents the material that all students should aim to know; *small type* contains data that would be consulted as special occasion arises." However, this device does not compensate for good organization and clear and concise presentation of fundamental data.

Other prominent deficiencies in the book are the absence of a discussion of the history of pharmacology and an all too cursory mention of the rapidly expanding field of drug metabolism.

In brief, *A Manual of Pharmacology* is chiefly a large reference volume in pharmacology. The non-systematic organization, the lack of instructional material such as diagrams, and the emphasis on drugs of only minor importance place this book outside the realm of useful textbooks for medical students or the general practitioner.

Carl C. Pfeiffer, M.D.

Wilburt C. Davison, M.D., and Jeana Davison Levinthal, M.D., **THE COMPLETE PEDIATRICIAN**, Duke University Press, Durham, N. C., 1947, 257 pp., \$4.25.

The well known dean and professor emeritus of pediatrics at Duke has produced another edition of his by-now famous *The Complete Pediatrician*, this time with the help of his daughter, Dr. Jeana Davison Levinthal. Dr. Levinthal is an instructor in pediatrics at the University of Michigan.

The book is still the concise, handy, and practical reference that it has been in the past, covering, in its way, the complete field of pediatrics. Dr. Davison says, "In contrast to many pediatric books which too often resemble the old-fashioned hoop-skirt in covering the subject without touching it, this book is like a G-string in touching the subject without any pretense of covering it, or even more aptly, like a brassiere in only touching the high spots."

Practically every pediatric high spot is touched somewhere in the book, and with the practical system of cross-indexing, is easy to find rapidly. The completeness is due in part to Dr. Davison's long-standing practice of giving members of his house staff a dime each time they could come up with a syndrome or condition not mentioned in previous editions.

The sections on symptoms and signs, with lists of all the diseases that may cause them, are still present and expanded. The book is full of all the small and large data which most pediatricians and general prac-

titioners need to have written down somewhere and easily accessible for memory-jogging purposes.

Much out-dated material has been deleted from the new edition, and condensations of all the new pediatric contributions of any practical importance, including new data on antibiotics, anticonvulsants, antihistamines, electrolytes, and steroids have been added.

One of the delightful things remaining in this edition is the short thesis on the advantages of evaporated milk as a base for infants' formulae:

"No teats to pull
No dung to fling
Just punch 2 holes
In the goddam thing."

This small, condensed, highly practical book with its wealth of necessary facts should be in reach of every physician who attends children.

Olin Shivers, M.D.

Pullen, Roscoe L., M.D., **PULMONARY DISEASES**, Lea and Febiger, Philadelphia, 1955, 669 pp., 195 ill., \$15.00.

This volume is composed of eighteen sections each of which is written by a different author, most of whom are well-known. The subjects are all related to pulmonary disease and are grouped mainly from a clinical standpoint. There is nothing new or startling in this book, but it is a brief, concise handling of the present day knowledge of pulmonary disease. As a reference it falls far short of some of the more detailed volumes and apparently is aimed at the man who has a more superficial interest in pulmonary diseases than the specialist. From this standpoint it is a quite good summary of the standard procedures and philosophy on pulmonary disease. Most of the authors have a pleasing style and the physiology is particularly well covered. I was struck with the inadequacy of the discussion of suppurative lung disease and at the same time with the excess of space given to the more rare diseases such as the benign tumors of the lung. However, all in all the volume is well balanced and makes interesting reading. It is particularly suitable for the practitioner who is interested in the diseases of the chest, but who is not a specialist.

Bernard P. Wolff, M.D.

Farris, Edmond J., Ph.D., **HUMAN OVULATION AND FERTILITY**, J. B. Lippincott Company, Philadelphia, 1956, 148 pp., \$6.50.

This book was written by Edmond J. Farris, Executive Director and Associate Member of the Wistar Institute of Anatomy and Biology. Dr. Farris has long been associated with investigation in the field of human fertility, both male and female, and has contributed many outstanding works.

The book deals almost entirely with ovulation of the human female in relation to fertility. The basic facts are derived chiefly by applying the rat hyperemia test to determine the time of ovulation. This test was originated and developed by Dr. Farris and is often referred to as the "Farris Test." It is performed by injecting the patients' urine (two cc) subcutaneously into immature white rats of the Wistar strain on consecutive days and observing and comparing the changes that occur in the rat ovary with a special color chart. The information presented further supports the value and accuracy of this test.

On the basis of information derived from this test some practical facts are presented in relation to the

timing of coitus in the infertile couple. This information is also applied as a means of preventing conception. The author presents statistics of fertile matings to support his observations.

This book is another important contribution in the endeavor to relieve the barren couple. Its usefulness is better expressed by the author, "if the work reported here should serve to stimulate further research in this field, one of our major objectives will have been attained," than by the publishers, "This book has been designed for and should prove especially useful to the clinician."

Samuel R. Poliakoff, M.D.

McNeill, Donald R., THE FIGHT FOR FLUORIDATION, Oxford University Press. New York, 1957, 236 pp., \$5.00.

For the past half century mottled enamel, later traced to fluorides in the drinking water, has concerned the health professions and the public. For more than ten years the subject of controlled (added) fluorides has been a controversial matter much like many other public health programs in their initial stages. This controversy has been largely a fight between the scientific professions and lay groups who have previously opposed immunization, pasteurization, and chlorination of public water supplies.

This book describes in detail the tremendous amount of work, time spent, and the obstacles faced by the early pioneers in this work on fluorides. Frederick McKay, G. V. Black, and others spent their own money and many years of hard work to determine that mottled enamel was caused by high concentrations of fluoride in the public water supply. H. Trendley Dean, Francis A. Arnold, Jr., and associates, largely U. S. Public Health Service employees, spent several years conducting epidemiological studies to find that one ppm. fluoride was an optimal amount needed to serve as a beneficial health measure rather than as a hazard to dental health. Assuming that added or controlled fluorides were as beneficial as fluorides found naturally in a public water system, Wisconsin dentists and certain State Health Department officials began a vigorous campaign to fluoridate all public water supplies in the State. This was done before the American Dental Association or U. S. Public Health Service had time to evaluate the effectiveness of added or controlled fluoridation. This bold adventure led to a conflict between the U.S. Public Health Service, the American Dental Association, and certain Wisconsin dentists and health officials, since the former advocated moving slowly and cautiously. Publicity accusing them of retarding fluoridation was launched by the Wisconsin group. This controversy aided the opponents of fluoridation and gave them an opportunity to question the practicability and safety of adding fluorides to the public water system.

By the time the controlled studies in Grand Rapids, Michigan, and Newburgh, New York, had advanced enough for the Association and the Service to approve general fluoridation of public water supplies, the fight in Wisconsin had reached a high pitch and was spreading throughout the nation. The author describes in detail many of these vicious fights between the unscientific groups and the health professions and their cohorts.

The fluoridation subject became so politically involved that congressional committees became interested and began public hearings. The opponents of fluoridation seized this opportunity to testify and, thereby fortify their position, and then proclaimed this testimony as scientific fact to local governing authorities. Referendums were demanded by the opponents and in many instances used successfully to defeat fluoridation. National magazines and local newspapers began publishing articles and editorials for and against fluoridation. This helped to further confuse the layman who knew little or nothing about fluoridation. In many instances, when forced to take a stand, the poorly informed public decided against fluoridation usually because they were uncertain about its benefits or its safety.

Despite the vicious opposition, fluoridation was adopted by more and more cities throughout the nation. Congress appropriated funds to fluoridate the Washington, D. C., water supply offsetting to some degree the testimony taken from the committee hearings and quoted by the opposition. Many city officials considered the matter too controversial to take any action while others adopted fluoridation both in the USA and foreign countries.

The author concludes that "the anti-fluoridation crusade was a political protest movement against the scientific organization and a government which heeded their wishes."

The book frankly describes in detail the violent and bitter contests that have been and still are being fought. The question now is whether or not we wish our future generations to have better or worse teeth. In the minds of the health profession fluoridation should not be classified as a controversial matter since every scientific health-minded profession has endorsed its use.

The fight for fluoridation is slowly winning favor throughout the country, which proves again that a scientific fact cannot be replaced permanently with doubt, fear, and false conceptions.

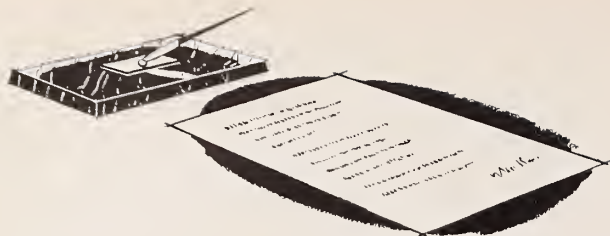
This is a good book for those interested in the promotion of fluoridation. The arguments by the opponents today are little different from those wild fantastic claims made in Wisconsin over ten years ago that are so well described by Donald R. McNeil in "The Fight for Fluoridation."

T. F. Sellers, M.D.

Do You Know?

Of the 1,775,000 suicides throughout the world each year, the highest death rates from this cause occur in Japan, Denmark, Austria, and Switzerland with the lowest number being reported from Ireland, Chile, Scotland and Spain. Japan has the highest suicide rate in the world, more than twice as high as that for the

United States. There were 16,200 suicides in the United States in 1955, as compared with 7,840 murders. A subconscious impulse to self-destruction is believed by many psychiatrists to be a factor in a considerable number of the 40,000 deaths in automobile accidents each year.



abstracts by georgia authors

Martin, J. D., Jr., and Thompson, Edgar B., III, Emory University School of Medicine, Emory University, Ga. "Spontaneous Hemorrhage into the Rectus Muscle: Two Case Reports and a Review of the Literature," *Am. Surgeon* 23:309-316 (April) 1957.

Hemorrhage into the sheath of the rectus abdominis muscle may produce a clinical picture that mimics an acute intra-abdominal condition. It may result from rupture of (1) either the superior or inferior deep epigastric artery, (2) the accompanying vein, (3) the rectus muscle, or (4) all of the above.

In a review of 107 cases reported, it is noted that the condition occurs twice as frequently in females as in males. It is usually ushered in with acute onset and is often associated with pregnancy.

Diagnosis is sometimes difficult, and exploration is necessary for confirmation. Bouchacourt's sign is a valuable aid in determining the presence of an abdominal wall mass. It is elicited by having the patient contract the abdominal wall. If the mass is subcutaneous, it becomes more manifest and retains its mobility. If it is intraperitoneal, it will disappear completely.

One should be alert to this condition in order that early treatment be rendered to lessen the morbidity and an unusually high mortality rate of 7.5 percent for the 107 cases reported. It should be emphasized that hemorrhage into the muscle alone does not cause death, but the associated conditions are usually responsible.

Wolcott, M. W., and Murphy, J. D., V.A. Hospital, Augusta, Ga., "The Changing Picture of Lung Abscess Therapy," *Dis. of Chest* 32:62-69 (July) 1957.

Sixty-five cases of lung abscesses are reported. These are divided into three groups. The sulfonamide period, 1941-1944, 19 cases; the penicillin period, 1944-1952, 29 cases; the antibiotic, or tryptar period, 1952-1956, 17 cases. Mortality has fallen progressively from 31.5 per cent in the first, to 17.2 per cent in the second, to zero in the latest group.

It is felt that several factors have contributed to the lowered mortality. Treatment has been instituted earlier

in each group, a larger number of effective antibiotics have been available, and chemical debridement with tryptar has proved very useful. Tryptar was used as an aerosol, 125 mg. daily or every other day for periods of two weeks to a month.

Resection has replaced drainage procedures when surgery is needed. Surgical management has been increasingly less necessary in each group, so that in the most recent series 65 per cent required no surgery for cure.

Greenblatt, Robert B., Medical College of Georgia, Augusta, Ga., "Treatment of Menopausal Symptoms," *Geriatrics* 12:452-3 (July) 1957.

This article presents briefly in question and answer form a discussion of the physiology and symptomatology of the menopausal period as well as the rationale for treatment.

What is the rationale of therapy in the menopause? In prescribing treatment there are many aspects of the menopause to be considered.

1. The psychogenic or "hypothalamic" factor may be treated with tranquilizing agents, and at times with stimulants, or with combinations of both. To this end, such tranquilizers as reserpine (Serpasil), meprobamate (Equanil), azacyclonal (Frenquel), chlorpromazine (Thorazine), and promazine (Sparine) have been used to advantage. When depression is a factor, stimulating agents such as dextro-amphetamine sulfate (Dexedrine) and methyl-phenidate hydrochloride (Ritalin) are valuable alone or in combination with tranquilizing agents.

2. The autonomic imbalance may be treated with automatic depressant drugs such as bellergal (phenobarbital, ergotamine tartrate, and belladonna alkaloids). This preparation alone is often not sufficient to completely allay all symptoms, and the addition of estrogens is necessary to assuage the symptoms of flashes and sweats.

3. The metabolic disorders are best treated by gonadal steroid therapy. Estrogens locally are recommended for senile vaginitis and pruritus vulvae; estrogens or androgens for frequency,

nocturia, and some forms of incontinence; and combinations of estrogens and androgens for osteoporosis, myalgias, and some forms of arthritides.

Goldman, Morris, Sc. D., Public Health Service, Atlanta, Ga. "Staining *Toxoplasma Gondii* with Fluorescein-Labelled Antibody: II" *J. Exper. Med.* 105:549-573 (June) 1957.

A new serologic test for antibodies to *Toxoplasma* is described, which is based upon inhibition of specific staining with fluorescent antibody. In performing the test a mixture of the test serum and known fluorescein-labelled antiserum is added to a dried smear of toxoplasms for one hour at 37°C. The smear is then rinsed and examined with a fluorescence microscope. Reduction in the brightness of fluorescence, as compared to that of a negative control slide, indicates the presence of antibody in the test serum.

A comparison of the results of this test with those of the methylene blue dye test showed a strong parallelism between the two sets of results. On the other hand, the complement-fixation test for toxoplasmosis did not yield nearly as many positives as the inhibition test.

The specificity of the new test was studied by comparing it with dye test results and clinical histories in human patients, and by testing a group of animals immunized with a variety of non-*Toxoplasma* antigens. No evidence of cross-reactions was obtained in the latter series.

Some advantages and disadvantages of the inhibition test are discussed.

Goldman, Morris Sc. D., C.D.C., Public Health Service, Atlanta, Ga. "Staining *Toxoplasma Gondii* with Fluorescein-Labelled Antibody: I" *J. Exper. Med.* 105:549-573 (June) 1957.

Antitoxoplasma globulin was labelled with fluorescein and was used to stain *Toxoplasma gondii* organisms in smears of peritoneal exudate. The evidence indicates that this staining was due to an antigen-antibody reaction at the cellular level. Methods are presented for handling the organisms so that they can be stained over a period of several months. Some general characteristics of the antigen system involved are described.

Witham, A. Calhoun, M.D., and Ellison, Robert G., M.D., Medical College of Georgia, Augusta, "Diagnosis of Ostium Primum Defects of the Atrial Septum," *Am. J. Med.* 22:593-604 (April) 1957.

On the basis of observations made in five cases, four confirmed at operation, the authors present criteria for the differentiation of atrioseptal (ostium primum) defects from ostium secundum defects. Ostium primum defects are commonly associated with a cleft mitral leaflet or otherwise incompetent mitral valve, accompanying regurgitant murmur, and left ventricular enlargement. Since defects of the ostium secundum are more amenable to correction by present surgical technics, the differentiation has practical implications in management.

Bartholomew, R. A., M.D.; Colvin, E. D., M.D.; Grimes, W. H., Jr., M.D.; Fish, John S., M.D.; Lester, William M., M.D.; Galloway, William H., M.D., Atlanta, Ga. "Facts Pertinent to the Etiology of Eclampsyogenic Toxemia," *Am. J. Obst. and Gynec.* 74:64-84 (July) 1957.

Young (1914) discovered a significant correlation between areas of placental necrosis and toxemia. Unfortunately no serious attempts were made to verify this important finding. Impressed with this relation, we have examined grossly and microscopically, since 1930, numerous formalin-fixed placentas from normal, preeclamptic, eclamptic and abruptio patients and found a positive clinicopathological correlation in 85 per cent. Explanation of the deficit of complete correlation (15 per cent) was found in the fact that 10 to 15 per cent of patients, entirely normal on admission in labor, were found to show heavy proteinuria at delivery, occasional hypertension for 12-24 hours and areas of distinct acute placental infarction. This transient intrapartum toxemia was seldom sufficient to cause clinical symptoms.

Spanner's discovery (1935) that sphincters are present in the placental veins was verified by us. The possibility suggested itself that the change in hormonal balance late in pregnancy may remove inhibitory effect of progesterone on Pitocin and Pitressin and not only initiate labor but stimulate sufficient contraction of the venous sphincters in some cases to block exit of blood from the placental units resulting in dilation of villus capillaries, enlargement of the villi, and diminution or obliteration of maternal intervillous circulation, thus causing acute anoxic necrosis of the chorionic epithelium, liberation of thromboplastin, and degradation products.

Preeclampsia and eclampsia are characterized by a localized type of infarction; abruptio by massive infarction, producing clots and placental separation. Further studies of a biochemical nature are being pursued in the Department of Biochemistry at Emory University, aided by a government grant—H 1400 (C-2).

Woodhall, J. P., 724 Hemlock St., Macon, Ga., "The Community Surgeon Looks at General Surgery," *Arch. Surg.* 75:152-155 (July) 1957.

In this editorial the expansion of surgical specialization, the function of the American Board of Surgery and the American College of Surgery, and the residency system as applied to the community surgeon are reviewed. It is pointed out that the trend toward greater specialization tends to limit the sphere of the general surgeon although he may be a diplomat of the American Board of Surgery. The limitations of the surgical board itself are discussed and the direction for improving postgraduate evaluation of surgeons indicated.

Abbott, Osler A., Kaplan, Abraham, and Pang, Tet H., Emory University Hospital, Emory University, Ga., "Comparative Studies of the Function of the Human Vagus and Sympathetic Nerves Relative to the Pulmonary Bed," *Surgery* 42:17-193 (July) 1957.

This paper discusses the lack of knowledge relative to the control of lesser circulation and reviews the knowledge available to date. Objective data is presented to show the marked correlation between pulmonary artery pressure and the delivered intratracheal ventilation pressure. References are made relative to work on the heart showing that the status of the host organ in regard to rate and contractility have a significant

effect upon blood flow and that a similar situation exists in the lung. Increased respiratory excursion of the lung following vagus nerve block in the human is demonstrated by showing a significant increase in the tracing excursion both in the pulmonary artery and the pulmonary vein following such block. Studies included comparative evaluation of the effect of sympathetic nerve block upon pulmonary artery pressure in health and studies of vagus nerve block on pulmonary artery and pulmonary venous pressure in the healthy lung. Results of these studies showed that (1) vagus nerve block may produce a greater excursion of the lung which will be reflected upon pressure tracings obtained from the pulmonary artery or vein. (2) Patients not presenting bronchospasm, procaine block of the vagus nerve does not produce striking effects upon pulmonary artery pressure except at high ventilation pressures. At this level the same response is seen as in bronchospastic patients, namely a decrease in systolic and diastolic pulmonary artery pressure. (3) Vagus nerve block affects pulmonary venous pressure in that it reflects changes in lung motility and pulmonary pressure resultant to such block. In normal lungs, pulmonary venous pressure tends to rise in response to block. In bronchospastic patients, pulmonary venous pressure tends to drop. (4) Sympathetic nerve block produces a relative rise in pulmonary artery pressure on the left side and an actual rise in pulmonary artery pressure on the right. (5) It is concluded that the autonomic nervous system does have a significant potential relative to the control of the lesser circulation, but it is felt that its action is exerted probably more by its effect upon the bronchial and bronchiole musculature than upon the musculature of the pulmonary vascular wall.

POLICIES FOR GEORGIA'S NURSES

The following policies for practicing as a registered nurse in Georgia have been set up by the Board of Examiners of nurses in Georgia.

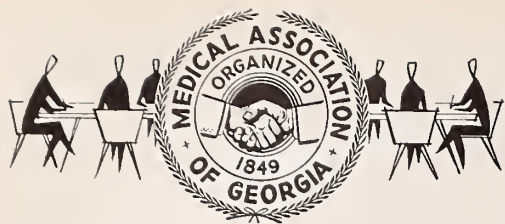
1. All nurses who work in the State of Georgia as graduate, registered, and/or professional nurses must be registered in the State of Georgia. See section 84-9915 and 84-9916 of the "Law Governing the Practice of Nursing in Georgia.

2. It is illegal to work one day without registration or a temporary permit. Contrary to current rumor, *there is no six month period of*

grace allowed. Temporary permits are issued only after applications for licensure are filed with the fee of \$15.00. Temporary permits allow applicants to nurse until registration is completed.

3. Graduate nurses working in doctors' offices must be registered in the State of Georgia.

4. The title *Graduate Nurse* is protected by law and it is illegal for anyone to work in the State of Georgia as a GRADUATE NURSE unless currently registered in Georgia.



the association

EXECUTIVE COMMITTEE

THE JULY MEETING of the 1957-58 Executive Committee of the Council of the Medical Association of Georgia was called to order by Chairman George R. Dillinger at 10:15 a.m., July 21, 1957, Headquarters Office, Atlanta, Georgia.

Members present included: W. Bruce Schaefer, Toccoa, President; Lee Howard, Sr., Savannah, President-Elect; Chris J. McLoughlin, Atlanta, Secretary-Treasurer; George R. Dillinger, Thomasville, Chairman of Council; and J. G. McDaniel, Atlanta, Chairman of Council Finance Committee. Also present was Edgar Woody, Jr., Atlanta, *JMAG* Editor; Mr. John D. Arndt, Atlanta, MAG Medicare Administrator; Mr. M. D. Krueger, Atlanta, Executive Secretary; and Mr. John F. Kiser, Atlanta, Asst. Executive Secretary.

Minutes of the Council of the Medical Association of Georgia meeting June 15-16, 1957, Macon, Georgia, were read and approved.

Medicare Report—Chris J. McLoughlin, Secretary-Treasurer, informed members of the Executive Committee of the replacement of Mr. Dougald Avera, former Medicare Administrator. Dr. McLoughlin then reported on the progress of the Medicare program with statistical data for the first six months of the program. He indicated that firm control of the program had been established and that the volume of claims received for processing was still increasing.

It was voted to approve the employment of Mr. John D. Arndt, with said costs contractually borne by the Government, beginning Aug. 16, 1957.

MAG Committee Reappointments—Chairman George Dillinger then called for nominations to replace former MAG Committee appointees who indicated they could not serve, and the following were appointed:

Hospital Relations Committee—Walter Brown, Savannah, replacing Peter Hydrick, College Park.

Public Service Committee—M. B. Sell, Jr., Augusta, replacing Peter Hydrick, College Park.

Woman's Auxiliary—Virgil Williams, Griffin, Chairman; Walker L. Curtis, College Park; Hal M. Davison, Atlanta; John L. Elliott, Savannah; W. G. Elliott, Cuthbert; with W. Bruce Schaefer, Toccoa, and Lee Howard, Sr., Savannah, serving as ex-officio members.

Blood Banks Committee—The American Red Cross Director to serve as an ex-officio member replacing George Dowling, Atlanta.

AMEF Committee—George T. Nicholson, Cornelia, Chairman, replacing Ben K. Looper, Canton, with Dr. Nicholson to select a replacement for Evelyn Swilling, Macon, and additional members he so desires.

Physician-Lawyer Liaison—In addition to the present members of the Physician-Lawyer Liaison Special Committee, who are Hal M. Davison, Atlanta, Chairman; W. Bruce Schaefer, Toccoa; Charles S. Jones, Atlanta; W. L. Pomeroy, Waycross; A. B. Conger, Columbus; with Mr. John A. Dunaway, serving as ex-officio member, the following members were appointed: Robert Gottschalk, Savannah; Charles Lamb, Albany; Enoch Callaway, LaGrange; Charles Richardson, Sr., Macon; Grady N. Coker, Canton; Thomas W. Goodwin, Augusta; with Henry Finch, Atlanta, serving as member-at-large.

MAG Vice-Councilors, First and Fourth District—Chairman Dillinger read the MAG Constitution and By-Laws, Chapter IV, Section 5. General Duties, as follows: "The Council shall by appointment fill any vacancy in office not otherwise provided for, which may occur during the interval between annual sessions of the Association. The appointee shall serve until his successor has been elected and installed." As vacancies exist in the offices of Vice-Councilor for the first and fourth district, the Executive Secretary was instructed to write the President and Secretary of the first and fourth district requesting these officers to select a single person to fill this vacancy and to mail these selections to the Council, for vote, as temporary appointees by Council. The Executive Secretary was further instructed to write the Secretaries of the first and fourth district informing them that at their next district meeting it should be their first order of business to nominate a Vice-Councilor so that these nominations may be presented for election at the 1958 Annual Session, April 27-30, 1958, Macon, Georgia.

MAG Special Attorney Shackelford Activity Report—Mr. M. D. Krueger reported on the progress of (a) Richmond County Medical Society constitution and Society answer to appeals filed with AMA Judicial Council concerning non-members, (c) MAG answer to appeals filed with AMA Judicial Council concerning non-members, and (d) MAG negotiation with Board of Regents re: Talmadge Memorial Hospital policy. Dr. Schaefer discussed the problems of certain non-members joining component medical societies outside the jurisdiction of their practice, and this item was referred to MAG Special Attorney Shackelford.

MAG Maturing Bond Reinvestment—J. G. McDaniel, Chairman of the Council Finance Committee reported that \$15,000 worth of Government bonds had matured, and on authorization of the Finance Committee, was reinvested as follows: Peachtree Federal Savings and Loan Association—\$5,000; DeKalb County Federal Savings and Loan Association—\$5,000; First Federal Savings and Loan Association of Atlanta—\$5,000. This reinvestment of Association funds was approved and referred to Council for final action. Dr. McDaniel also gave the monthly budget report which was reviewed and accepted for information.

Headquarters Office Air Conditioning—Chris J. McLoughlin, Secretary Treasurer, reported that on authorization of Finance Committee, as empowered to act per

the June 15-16 Council meeting, and with the permission of the Fulton County Medical Society, a contract was let for the air conditioning of the Headquarters Office, including Medicare, not to exceed \$2,000. By general agreement, this contract was approved, and Chris J. McLoughlin was instructed to sign this agreement in behalf of the Association.

AMA Public Relations Conference August 27-28, 1957—Chris J. McLoughlin discussed the forthcoming AMA Public Relations Conference scheduled for August 27-28, 1957, Chicago, Illinois. It was voted to send John Heard, Decatur, Chairman of the MAG Public Service Committee, and Messrs. Krueger and Kiser to attend this meeting. The motion further stated that Dr. Heard and Mr. Kiser's travel expense should be charged to the Public Service appropriations and Mr. Krueger's travel expense be charged to Office Travel.

VA Contract Extension—Chris J. McLoughlin discussed a request for extending our present VA contract beyond the 60 day limit approved by Council at their June 15-16 meeting, and asked that the contract be extended 90 days, allowing ample time for renegotiation. This request for extension was approved.

Americus Nursing School Publicity—Mr. Krueger reported that at the June 15-16 Council meeting a request submitted by Rural Health Committee Chairman J. Lee Walker for approval of use of the Association's name in publicizing the South Georgia Trade and Vocational School of Practical Nursing has been referred to the Sumter County Medical Society for clearance. On receipt of correspondence from the president of Sumter County Medical Society, which expressed the Society's opinion favorably, it was voted to approve the above request.

Medical School Course Committee Report — Chris J. McLoughlin, Chairman of the Council Committee on Medical School Courses, reported that the resigning and instituting of required courses at both of the medical schools of Georgia on the subject of the "Art of the Practice of Medicine" was progressing and that the committee was meeting weekly in laying out the course curriculum.

Physician-Institution Relations Committee Report—Mr. Krueger presented a report of the Council Committee on Physician-Institution Relations in behalf of the Committee Chairman, Dr. F. G. Eldridge. The following board statements of ethics regarding relationships between hospitals and pathologists, anesthesiologists, physical medicine, were submitted to the Executive Committee of Council for approval:

- (1) Adequate service guaranteed by physicians to satisfy needs and requirements of the members of the medical staff of the hospital.
- (2) Charge for services rendered by these physicians must be in the name of the physician in charge of the service.
- (3) That no employer-employee relationship exist between the hospital and the physician as such relationship is unethical and illegal.
- (4) Any arrangement made with the hospital by the physician should be of such a nature as to require payment for professional services by Blue Shield rather than Blue Cross and this is strongly recommended.

- (5) These basic principles of medical ethics so stated should apply to all hospitals admitting "pay patients" regardless of size, and to all physicians practicing in the state of Georgia.

After discussion of these principles, it was noted that the Committee is going to seek the opinion of the Georgia Radiological Society, the Georgia Association of Pathologists, the Georgia Society of Anesthesiologists, and the Physical Medicine men on these principles and then submit a revision of these principles to the full Council for approval. It was recommended that these principles be accepted for information only by the Executive Committee of Council.

MAG 1958 Annual Session Report—Mr. Krueger reported on the progress in designing the scientific program, meeting room facilities, scientific and commercial exhibit arrangements, and requested that suggestions be given Annual Session Committee Chairman Henry Tift on the general outline of the program. After discussion the following schedule was recommended:

- SUNDAY**—Section Meetings in the afternoon followed by the House of Delegates.
- MONDAY**—GP Day in the morning followed by a General Session at noon, followed by Section Meetings in the afternoon, followed by GP Day reconvened in the evening.
- TUESDAY**—Section Meetings in the morning followed by Section meetings in the afternoon, followed by the President's Dinner.
- WEDNESDAY**—House of Delegates meeting in the morning immediately followed by a General Session at noon.

This represents a suggested change in the scheduling of the Second Session of the House of Delegates in that it formerly was held Tuesday afternoon and it was recommended that it be held Wednesday morning, thus allowing Tuesday afternoon for section meetings.

Unfinished Business—Chris J. McLoughlin recommended that the Athens-Barrett case be re-referred back to the Professional Conduct Committee. This recommendation was approved.

Chairman of Council George Dillinger then appointed the Council Committee on Association Distinguished Service Award as follows: David Henry Poer, Chairman, Atlanta; C. F. Holton, Savannah; and Ralph H. Chaney, Augusta. It was recommended that the ground rules for such an award be established by this committee, and that this committee report to the full Council at their September meeting.

State Board Activity Report—Mr. Kiser reported on State Board meetings attended, including the Board of Medical Examiners, the State Board of Health, the State Medical Education Board, the Hospital Indigent Care Committee, and the Hill-Burton Advisory Committee, and by general agreement, it was recommended that the Executive Secretary write all State Boards asking, as a courtesy, that the MAG Secretary-Treasurer of the Association be invited to attend their meetings when not in executive session and further that the MAG Secretary-Treasurer be furnished an agenda and minutes of these meetings. The report was accepted as information.

New Business—Mr. Krueger presented a communication from the Georgia Tuberculosis Association requesting MAG participation in a state conference on blood

banks which would initiate a study of the over-all blood programs in Georgia. It was recommended that this matter be referred to the MAG Blood Banks Committee and that the Blood Banks Committee should report to the Executive Committee of Council by their August meeting.

Mr. Krueger then presented a communication from the AMA Bureau of Health Education which requested representation of the Association in attendance at the 6th National Conference of Physicians and Schools, October 30-November 2, 1957, Chicago. Mr. Krueger was instructed to get additional information from other state associations on this matter, and the matter was taken under advisement and referred to the full Council meeting in September.

The date of the August Executive Committee of Council meeting was set for August 11, 1957, 10 a.m., MAG Headquarters Office, Atlanta. The date for the September Executive Committee of Council meeting was set for September 14th, 10 a.m., Headquarters Office, Atlanta. The date for the September full Council meeting was set for September 14, 1957, 1 p.m., Headquarters Office, Atlanta, and arrangements were recommended to allow the Council to attend the dedication of Crawford W. Long Memorial in Jefferson, Georgia, on September 15, 1957.

There being no further business, the meeting was adjourned.

Attest: Mr. Milton D. Krueger

HOSPITAL RELATIONS COMMITTEE

THE HOSPITAL RELATIONS COMMITTEE of the Medical Association of Georgia was called to order by Co-Chairman David Henry Poer, Atlanta, at 1:35 p.m., Room 820, Dempsey Hotel, Macon, Georgia.

Committee members present included: David Henry Poer, Atlanta, Co-Chairman; Kirk Shepard, Thomasville; Robert B. Martin, Cuthbert; Walter E. Brown, Savannah; James R. Paulk, Moultrie; and A. W. Simpson, Jr., Washington. Also present was Mr. Milton D. Krueger, MAG Executive Secretary.

Guests of the Hospital Relations Committee present included: R. C. Williams, Division of Hospital Services, State Department of Health; Mr. Millard Wear, President-Elect, Georgia Hospital Association; and Mr. Glenn Hogan, Executive Secretary, Georgia Hospital Association.

Co-Chairman Poer called on Mr. Krueger to review the minutes of the last meeting of the MAG Hospital Relations Committee held at 11:00 a.m., April 8, 1956, Sidney Lanier Cottage, Macon, Georgia.

Co-Chairman Poer then commented that because a majority of physicians practice medicine in a hospital, the problems of physician-hospital relationships are within the jurisdiction of the Association. He further

stated that he believed it to be the responsibility of the Hospital Relations Committee to advise Council and the House of Delegates on matters within this jurisdiction, and to further become cognizant of the relationships with the State Board of Health and the Hill-Burton Hospital program and the licensure of hospitals by the State Department of Health.

Dr. Poer then called on Dr. R. C. Williams who gave the background of the Hill-Burton Act and information regarding the licensing of hospitals in the state of Georgia. Dr. Williams stated that there were 237 hospitals in Georgia, and of these, 100 are small hospitals defined as one to 15 beds and usually physician-owned. Dr. Williams stated that the licensure objectives were concerned with the physical safety of the patient only, and that the approach to these licensure objectives was educational rather than arbitrary. Dr. Williams said that perhaps 50 per cent of the hospitals in Georgia have met these minimum standards, but that the smaller hospitals still remain a problem. He also stated that medical records are a problem in all types of hospitals.

Dr. Poer and other members of the Committee stated that it is the Association's responsibility to be concerned with the professional standards in hospitals. Drs. Simpson, Shepard, Paulk and Martin, concurred and approved the policy of the Association being within its jurisdiction in determining certain minimum standards for professional care rendered in hospitals. It was further suggested that the Association set up some minimum professional standards and certificates be awarded smaller hospitals meeting these standards and that this be an educational program rather than a "police action."

It was further agreed that these standards should be applied to "25 bed or less" hospitals and that the criteria should allow certain leeway for these smaller hospitals. Also agreed was that this program should be one of moderation and education with an eye toward improving the standards over a period of many years. To effect this project it was recommended that the Medical Association of Georgia cooperate with the Georgia Department of Public Health and the Georgia Hospital Association in that the *Medical Association of Georgia* should ascertain *professional standards*, the *Georgia Department of Public Health* should ascertain certain *physical standards*, and the *Georgia Hospital Association* should ascertain *administrative and management standards*, and again that the program should be confined to hospitals of 25 beds or under.

Co-Chairman Poer then appointed Milford Hatcher, Chairman of a Subcommittee on Hospital Minimum Standards, with Drs. Martin and Tyler as Subcommittee members.

Dr. Poer then called on Millard Wear, President-Elect of the Georgia Hospital Association who agreed that hospital standards is probably the most important problem in the field of hospital-physician relationships. He emphasized that committees for better relationships between the medical staff and the hospitals should be formed for each medical staff and hospital and that financial problems of the hospital should be made known to the medical staff. He further discussed the Georgia Indigent Care Program.

Mr. Glenn Hogan emphasized the need of paramedical personnel. After discussion of this problem, Dr. Poer appointed a Subcommittee on Paramedical Per-

sonnel ecruitment to be known as the Medical Allied Service Subcommittee, with Dr. Walter Brown, Chairman, and Drs. Paulk, and Simpson, members of this committee.

Dr. Poer then discussed with members of the Committee, the report of the Council Committee on Physician-Institution Relationships which dealt specifically with the relationship between radiologist, pathologists, anesthesiologists, and physical medicine physicians with the hospital. It was generally agreed that a liaison member of this Hospital Relations Committee should meet with the Physician Institution Relations Committee, and to effect such liaison Dr. Shepard and Dr. Banks were appointed.

Dr. Poer then emphasized the need for liaison with the governing board authorities and called on Dr. Williams who gave the history and background of the Georgia Association of Hospital Governing Boards. By general agreement it was approved that a subcommittee of the Hospital Relations Committee be appointed for liaison to meet with Georgia Hospital Association officials, and appointed to this subcommittee were Drs. Hatcher, Poer, Banks, Tyler, and Goodwin as members.

The last item of business was the next meeting of the Committee, and it was agreed to meet on a Sunday early in November, the date to be set by the chairman and co-chairman. The Committee then accepted the invitation of Dr. Paulk to hold this November meeting in Moultrie.

There being no further business, the meeting adjourned.

Attest: Mr. Milton D. Krueger

MAG 1958 ANNUAL SESSION PROGRAM COMMITTEE

AT A MEETING of the MAG 1958 Annual Session Program Committee the following scientific and business program was approved and tentatively set up for the Association's *104th Annual Session, April 27-30, 1958, Macon, Georgia.

SUNDAY, APRIL 27, 2:00 p.m. to 5:00 p.m.
—*Section Meetings*, (1) Pediatrics, and Radiology Joint Section (2) Psychiatry and General Practice Joint Section; 5:00 p.m. to 6:30 p.m.—*MAG House of Delegates*; 6:30 p.m. to 7:30 p.m.—*MAG House of Delegates Social Hour*.

MONDAY, APRIL 28, 9:00 a.m. to 12:00 noon—*General Session "G. P. Day"*; 12:00 noon to 1:00 p.m.—*General Session Business Meeting*; 2:30 p.m. to 5:00 p.m.—*Section Meetings*, (1) Orthopedics, Surgery, Anesthesiology, Pathology, and Industrial Surgery Joint Section (Trauma) (2) Medicine, Neurosurgery, Radiology and EENT Joint Section (Hypertension); 5:00 p.m. to 8:00 p.m.—*Alumni Dinners*; 8:00 p.m. to 9:30 p.m.—*General Session "G. P. Day" Re-convened*.

TUESDAY, APRIL 29, 9:00 a.m. to 12:00

noon—*Section Meetings*, (1) Medicine, Chest, Diabetes, and EENT Joint Section (2) Obstetrics and Gynecology, General Practice and Anesthesiology Joint Section; 12:00 noon to 1:00 p.m.—*General Session Lectureship*; 2:30 p.m. to 5:00 p.m.—*Section Meetings*, (1) Obstetrics and Gynecology, Pathology and General Practice Joint Section (2) Surgery Section; 6:30 p.m. to 7:30 p.m.—*Social Hour*; 8:00 p.m.—*MAG President's Dinner*.

WEDNESDAY, APRIL 30, 9:00 a.m. to 11:30 a.m.—*MAG House of Delegates* (2nd Session); 11:30 a.m.—*General Session Business Meeting* (2nd Session).

The floor plan for the Association meetings held in the Macon Auditorium has been designed with ample space for Scientific Exhibits. Members are urged to display Scientific Exhibits at this meeting. For details please write: Dr. Ted F. Leigh, MAG Scientific Exhibits Chairman, Radiology Department, Emory University Hospital, Emory University, Georgia.

ANNOUNCEMENTS

Six Days of Cardiology—Emory University School of Medicine, Jan. 13-18, 1958. Major problems of heart disease will be discussed by members of the Emory University faculty and visiting doctors. Tuition fee, \$100. For further information write to the Postgraduate Teaching Program, Emory University School of Medicine, 69 Butler St., Atlanta 3, Ga.

The Academy of Psychosomatic Medicine—Morrison Hotel, Chicago, Ill., October 17-19, 1957. This fourth annual meeting will be devoted to "Psychosomatic Aspects of Obstetrics, Gynecology, Endocrinology, and Diseases of Metabolism." The purpose of this meeting is to teach psychosomatic medicine in a manner assimilable to the general practitioner and non-psychiatrically oriented physician. Panels and symposiums will include specialists in various fields of medicine. Detailed information may be obtained from William S. Kroger, M.D., Secretary, 104 Michigan Ave., Chicago, Ill.

Postgraduate Courses on Diseases of the Chest—12th Annual, Hotel Knickerbocker, Chicago, Ill., October 21-25; 10th Annual, Park-Sheraton Hotel, New York City, Nov. 11-15; 3rd Annual, Ambassador Hotel, Los Angeles, Calif., Dec. 9-13. Tuition for each course is \$75. The most recent advances in the diagnosis and treatment of chest disease, medical and surgical, will be presented. Further information may be obtained by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut St., Chicago, Ill.

Course in Occupational Skin Problems, presented by the Department of Preventive Medicine and Industrial Health, The Kettering Laboratory, Cincinnati, Ohio, October 28-November 1, 1957. General objective of program is to fulfill the professional needs of the industrial physician and to provide him with a greater

ANNOUNCEMENTS / continued

understanding of the pathogenesis, diagnosis, treatment, prevention and control of cutaneous disorders of occupational origin. Program will consist of didactic lectures and clinical demonstrations, afternoon field instruction in industrial plants, and evening panel discussions. Registration fee, \$100. For further information write to the Secretary, Institute of Industrial Health, The Kettering Laboratory, Eden and Bethesda, Cincinnati 19, Ohio.

The American Fracture Association, 18th Annual Meeting—Hotel Cortez, El Paso, Texas, Sept. 30-October 2. Program will consist of round table luncheons, discussions, and numerous scientific and commercial exhibits. Following the meeting which will end Oct. 2, there will be a postgraduate trip to the Medical University, Guadalajara, Mexico. For further information write The American Fracture Association, 610 Griesheim Bldg., Bloomington, Ill.

*Third World Tour Postgraduate Clinical Course—*Sponsored by the International College of Surgeons. A professional trip, leaving San Francisco, Oct. 20, and returning to New York, Dec. 7. Fellows of the International College of Surgeons have arranged lectures, clinical demonstrations, and entertainment in Hong Kong, the Philippines, Thailand, India, Turkey, and Greece. Families and friends will be accommodated. Detailed information may be obtained from the International Travel Service, Inc., Palmer House, Chicago.

DEATHS

THOMAS JEFFERSON ARLINE, retired Cairo physician, died at Grady County Hospital, July 7, at the age of 91. Dr. Arline was born January 24, 1866, in what was then Decatur, now Grady County. He was graduated in medicine from the University of Louisville, Kentucky, and began his practice at Baconton, Ga. Two years later he moved to Cairo.

In 1949 Dr. Arline was jointly honored by the Medical Association of Georgia and his alma mater, the University of Louisville, for his 50 years of service to the medical profession.

Funeral services were held at the First Methodist Church of which he was an active member. Survivors include two sons, T. Alton Arline and T. J. Arline, Jr.; three daughters, Miss Myrtice Arline, Mrs. John B. MacQuidy, and Mrs. Charles Whatley; and six grandchildren.

BENJAMIN R. BUSSELL, 73, Waycross, died in Memorial Hospital, July 14. Dr. Bussell was born in Abba, Georgia in 1884. He attended medical school at the Atlanta College of Physicians and Surgeons, now Emory University, and in 1926 he moved from Rochelle to begin practice in Waycross. For many years he was chief anesthetist at Ware County Hospital.

Dr. Bussell was a 32 degree Mason, a Shriner, and a deacon of the First Baptist Church of Waycross.

Survivors include his wife, Mrs. Evelyn Dorminy Bussell; one daughter, Mrs. Clarence Eidson; one brother; two sisters; and three grandchildren.

T. W. JACKSON, 82, Manchester died at his home on April 30, after a month's illness due to a cerebral

hemorrhage.

Dr. Jackson was born in Habersham County. He attended Dahlonga College (University of Georgia) and graduated in 1909 from the Atlanta School of Medicine, now Emory University.

Dr. Jackson came to Manchester in 1909, the same year the city was incorporated. He was a deacon and charter member of the First Baptist Church. In 1911 he helped to organize the First Baptist Sunday School and was the first superintendent. He served as secretary-treasurer of the church for eight years.

He was a life member of the Meriwether Medical Society, a member of the Medical Association of Georgia, American Medical Society, and the Woodmen of the World.

In 1953 the Manchester Junior Chamber of Commerce presented Dr. Jackson with a bronze plaque for his service to his community.

Survivors include his wife, Mrs. Lillie Mann Jackson; one daughter, Mrs. W. B. Pournelle; two sons, Wofford L. Jackson and Dr. Calvin Jackson; and seven grandchildren.

E. J. SMITH, 84, Hahira, died August 1 following a long illness.

He was born in Leesville, S. C. and reared in Augusta, where he attended the Medical College of Georgia.

Dr. Smith was a member of the American Medical Society, the Medical Association of Georgia, and the South Georgia Medical Society. He was a former director of the Commercial Bank of Hahira and had served as mayor of the community for 20 years. He was a member of St. John's Evangelistic Roman Catholic Church.

Survivors include his wife, Mrs. E. J. Smith; one daughter, Mrs. Walter R. Salter; one son, Dr. J. R. Smith; two stepdaughters; two stepsons; and one grandson.

SAMUEL A. VISANSKA, 88, Atlanta's first recognized pediatrician, died unexpectedly at his home, July 18. Born in Abbeville, S. C. in 1869, Dr. Visanska studied at the Philadelphia College of Pharmacy, the South Carolina Medical College, and later took special training at New York and other medical centers. Dr. Visanska was "famous as the man who changed the shape of the baby diaper from a triangle to an oblong."

Dr. Visanska was physician to and one of the founders of the Atlanta Home for the Incurables. He established the children's clinic, Wesley House, at the Fulton Bag and Cotton Mill. He was a member of the Medical Association of Georgia, the American Medical Association, the Georgia Pediatrics Society, and a life member of the Fulton County Medical Society.

Survivors are his wife, formerly Miss Florence Field; one daughter, Mrs. Joseph R. Sternberg; one son, S. A. Visanska, Jr.; one sister; and two grandchildren.

SOCIETIES

The BULLOCH COUNTY MEDICAL SOCIETY recently sponsored an adult polio vaccination clinic in Statesboro.

The TIFT COUNTY MEDICAL SOCIETY recently passed a resolution endorsing the fluoridation of Tifton's water supply. The society cited "convincing evidence" of the safety and health benefits of the procedure and

called on city officials to consider fluoridation.

The regular bi-monthly meeting of the **SOUTH-WEST GEORGIA MEDICAL SOCIETY** and the Woman's Auxiliary was held at Fort Gaines recently. Dr. and Mrs. H. P. Wood of Fort Gaines were hosts, J. G. Stanfer, president, presided. The program was presented by Frederick H. Thompson and O. Gray Rawls, both of Albany.

The **FOURTH DISTRICT MEDICAL SOCIETY** is to be congratulated on their \$300 contribution to the A.M.E.F. The money is to be used for the medical schools in the state of Georgia.

At an August meeting of the **FULTON COUNTY MEDICAL SOCIETY**, Thomas C. McPherson, Tom S. Howell, and Samuel S. Ambrose conducted a panel discussion on acute appendicitis in children. At this same meeting Arthur J. Merrill was named temporary chairman of the Emory-Grady-FCMS coordinating committee. This committee was set up to deal with problems concerning the two institutions and the society.

At a recent meeting of the **FULTON COUNTY MEDICAL SOCIETY**, Carl A. Whitaker, psychiatrist, Rhodes Haverty, pediatrician, and David F. James, internist, conducted a symposium on "Aspects of Obesity."

The **NEWTON-ROCKDALE COUNTY MEDICAL SOCIETY** recently elected James W. Purcell to succeed the late Clarence Palmer as secretary of the society.

Members of the **WASHINGTON COUNTY MEDICAL SOCIETY** were recent guests of the Washington County Hospital Authority at a dinner meeting in the Rawlings Memorial Hospital dining room. The purpose of the meeting was to keep the doctors informed of the authority's activities and to ask that the doctors act as an advisory body in the planning and operation of a projected hospital.

Vincent J. Cirincione, Savannah dermatologist, addressed a recent meeting of the **WARE COUNTY MEDICAL SOCIETY**. Dr. Cirincione spoke on the "Common Skin Diseases as Seen by the General Practitioner."

The **TENTH DISTRICT MEDICAL SOCIETY** held its semi-annual meeting last August in Elberton. Following the luncheon meeting, the scientific meeting was held at which the following papers were presented: "Problems of the Newborn" by T. Ed Bailey, Augusta; "Surgery in the Treatment of Parkinsonism" by Pomeroy Nichols, Augusta; "Significance of Enuresis" by R. C. Thompson, Athens; and "Some Cutaneous Neoplasms" by W. Harvey Cabaniss, Jr., Athens. Following this the regular business meeting was held wherein the following officers were elected for the ensuing year: J. Hubert Milford, Hartwell, President; Stewart D. Brown, Royston, Vice-President; W. Harvey Cabaniss, Jr., Secretary-Treasurer, Athens.

PERSONALS

First District

VINCENT J. CIRINCIONE, Savannah dermatologist, addressed a recent Savannah Lions Club meeting on the subject of emotional and summer skin diseases.

John Joseph Doolan is now associated with H. F. SHARPLEY and W. W. OSBORNE, Savannah, in the practice of gynecology. Dr. Doolan received his pre-medical training at Spring Hill College, Mobile, Ala., and his M.D. degree from St. Louis University School of Medicine. He served his rotating internship at Walter Reed Hospital, Washington, D. C. He was recently chief resident in obstetrics and gynecology at the University Hospital and Talmadge Memorial Hospital in Augusta.

CURTIS G. HAMES, Claxton, spoke recently to a staff meeting of the Bulloch County Hospital explaining the new Transaminase test for heart muscle damage.

W. W. HILLS, SR., Sardis physician, was honored at a special service at the Sardis Baptist Church in recognition of his contributions to the growth and progress of the community during his 47 years of medical service there.

JOHN D. McARTHUR, Lyons, has left for Orlando, Florida, to spend two years residency in surgery at the Orange Memorial Hospital. After completion of his studies, Dr. McArthur will return to Lyons to resume his practice.

Julian K. Quattlebaum, Jr., son of JULIAN K. QUATTLEBAUM, SR. of Savannah, has completed six years of residency at Johns Hopkins Hospital and has returned to Savannah to begin the practice of surgery.

Second District

J. C. BRIM, Pelham, has announced that William C. Arwood is now associated with him in the practice of medicine. Dr. Arwood received his M.D. degree from Emory University and served his internship at the Walter Reed Army Hospital.

C. L. HOWARD, Pelham, was a recent guest of the Professional Women's Club of Pelham. Dr. Howard showed films on blood transfusions and three types of bacteria.

FRANK K. NEIL, Albany, was recently featured in the sports section of the Albany Herald. Dr. Neil was cited as one of Vanderbilt's all-time football greats, and many of his early feats on the football field were recounted.

New nursery equipment was installed in the Brooks County Hospital in memory of the late L. A. SMITH of Quitman who died last year.

L. W. Willis, Jr., son of L. W. WILLIS, SR., of Bainbridge, has joined his father in practice in offices located on South West Street, Bainbridge. The younger Dr. Willis attended Tulane University and the University of Georgia and received his Doctor of Medicine degree from the Medical College of Georgia. He

PERSONALS / continued

interned at the Charity Hospital of Louisiana and the Macon City Hospital.

Third District

WILLIAM R. ANDERSON, Americus, has resumed his practice at his local office following completion of a year's training in pediatrics at Children's Hospital in Washington, D. C.

C. C. GOSS, WOODROW GOSS, and J. W. REYNOLDS, all of Ashburn, have moved their offices to the new Ashburn Doctor's Clinic located at East Washington Street.

E. W. WALDEMAYER, Americus, has been named county physician to replace RUSSELL THOMAS, who has resigned due to ill health.

Fourth District

ED T. ARNOLD, Hogansville, has been named one of the editors of the national publication "Medical Digest." Dr. Arnold is one of the two doctors from the Southeast selected on the magazine's editorial staff.

Fifth District

TED F. LEIGH, JOSEPH C. MASSEE, WILLIAM R. CROW, JR., ELIZABETH K. ADAMS, SHELLEY C. DAVIS, and F. KELLS BOLAND, JR., Atlanta physicians, were featured recently in the *Atlanta Constitution* in a series on doctors and their hobbies.

WILLIAM H. GALVIN, Emory University, has been named to the new administrative post of chief of anesthesiology at the Emory School of Medicine. Dr. Galvin is the author of articles on anesthesia appearing in medical journals and is a member of the American Society of Anesthesiologists.

TED F. LEIGH, Atlanta, has recently been elected president of the Atlanta Radiological Society. Other officers selected include JOHN O. ELLIS, Vice-President; and J. LUTHER CLEMENTS, Secretary-Treasurer.

GUY V. RICE, Atlanta, director for the Georgia Department of Public Health spoke to Savannah health authorities on the possibilities of Savannah's participation in the state mental health program.

Sixth District

Y. HARRIS YARBROUGH, Milledgeville, was honored recently by a surprise birthday party given by the staff of the Milledgeville State Hospital.

Seventh District

ENOS J. REILLY, former instructor at the Medical College of Georgia, Augusta, has joined HENRY D. MEADERS, Marietta, in the practice of obstetrics and gynecology at 413 Campbell Hill Street.

HART S. ODOM, LaFayette, is the new district medical director for the four counties of Catoosa, Dade, Walker, and Catooga.

WILLIAM R. THOMPSON, Calhoun, is now associated with CHARLES K. RICHARDS and BILL PURCELL in the practice of medicine. Dr. Thompson had formerly practiced in Summerville.

A. F. ROUTLEDGE, Rome, was named temporary secretary-treasurer of the newly-formed board of directors for the North Georgia Clinic for the Crippled.

DAVID E. TANNER, Marietta, has joined W. H. MATHIS, JR., as associate in radiology at Kennestone Hospital.

SIDNEY L. SELLERS, formerly of Atlanta, has opened offices for practice in obstetrics and gynecology in Dalton. Dr. Sellers will be located on Alabama Street.

LLOYD WOOD has returned to practice in Dalton following two and a half months of postgraduate work at Polyclinic Hospital, New York.

Eighth District

JOHN D. FARRIS, formerly of Atlanta, has recently opened offices in Waycross to begin the practice of obstetrics and gynecology. Dr. Farris will be located at 202½ Folks Street.

Four foreign doctors have arrived in Waycross to study public health center operations and rural health practices under the direction of J. F. HOOKER, regional medical director of the Southeastern Health Region.

WALTER R. MCCOY, Folkston physician, has retired from the active practice of medicine after 35 years of service to his community. Dr. McCoy received his M.D. degree at Emory University and served his internship at Georgia Baptist Hospital. He first came to Folkston in 1927. In 1948 he was elected to the Georgia State Senate where he served on the Public Health and Highways and the Appropriations committees. He was recently associated in the practice of medicine with J. M. JACKSON of Folkston.

T. L. PARKER, Douglas, has announced that Disken Morgan, formerly of Douglas, will be associated with him in the practice of medicine. Dr. Morgan received his education from South Georgia College, the University of Georgia, and the Medical College of Georgia at Augusta.

HORACE LEE MORGAN, formerly of Arlington, has recently moved his offices to Baxley. Dr. Morgan is located in the Economy Drug Store Building.

Ninth District

ROBERT A. BURNS, Blue Ridge, has announced that Thomas N. Pirkle of Smyrna is now associated with him in the practice of medicine and surgery at the Burns Clinic. Dr. Pirkle is a graduate of the University of Georgia and the Medical College of Georgia. He completed his internship at Athens General Hospital, Athens.

ERNEST R. HARRIS, Winder, was recently presented with a 5-year pin and a certificate of distinction for service to his profession by the Medical Association of Georgia.

Warren D. Stribling has joined HENRY S. JENNINGS of Gainesville in the practice of medicine. Dr. Stribling is a graduate of the Citadel and the Emory University School of Medicine. He served his internship at Henry Grady Memorial Hospital, Atlanta. He was

recently associated with the Department of Cardiology at Emory University.

J. G. WOODWARD, Dahlonga, has announced that A. A. Boggus, Jr., is now associated with him in the practice of medicine. Dr. Boggus attended Mercer University and graduated from the Emory University

School of Medicine. He interned at Grady Memorial Hospital in Atlanta.

Tenth District

G. LOMBARD KELLEY, Augusta, has been voted a charter member of the newly organized Society for the Scientific Study of Sex.

SOUTHERN MEDICAL ASSOCIATION HOLDS GROUND-BREAKING

The first step in the construction of the Association's \$225,000 headquarters office building took place in Birmingham on August 4, when the traditional ground-breaking ceremony was held at the building site. Located on a nearly one acre plot at Highland Avenue and Niazuma on the Southside, the modern structure will symbolize the beginning of the second half-century of the Association's progress.

The program, presided over by J. P. Culpepper, Jr., Hattiesburg, Mississippi, President, included addresses by Robert C. Berson, Dean, Medical College of Alabama; R. L. Sanders, Trustee, Memphis, Tennessee; Lee F. Turlington, Chairman of the Home Building Committee, Birmingham; A. Clayton McCarty, Chairman of the Council, Louisville, Kentucky, and Mr. C. P. Loran, Advisor and Professional Relations Counselor and Secretary of the Home Building Finance Committee of the Association. Greetings from the Woman's Auxiliary were extended by Mrs. John M. Chenault, Decatur, Alabama, Councilor from Alabama and Mrs. Walker L. Curtis, Atlanta, President-elect of the Auxiliary. The invocation was delivered by Dr. John H. Buchanan, former distinguished pastor of Southside Baptist Church, Birmingham.

More than 100 distinguished physicians from all over the south, along with state and local officials and civic leaders, attended the ceremony.

Scores of telegrams of congratulations and good wishes were received from national, state, and regional societies and from distinguished members and friends of the Association throughout the nation, including the President of the United States.

The building, to be constructed from glass, marble, brick, and stainless steel will be one of the most modern and completely functional buildings in the South. When completed, it will house the Association's entire operation, including the executive offices, the editorial and business offices of the *Southern Medical Journal*, the Association's official publication, the offices of the Woman's Auxiliary and will provide reserve facilities for the future growth of the Association. The cost of the building is being partly financed by contributions from members and friends of the Association.

The offices of the Association have been situated

in leased property in downtown Birmingham and at the present address since 1915. Since 1906, the birthdate of the Association, the organization has grown from a few members from the original states of Tennessee, Alabama, Georgia, Mississippi, Louisiana and Florida, to an organization of nearly 10,000 members in sixteen southern states, the District of Columbia, Puerto Rico, Panama Canal Zone and the Virgin Islands. The finest in Medicine in the South has been closely identified with the establishment, development and growth of the Southern Medical Association.



Jack C. Norris, Atlanta, "breaks ground" for the new headquarters of the Southern Medical Association in Birmingham. Dr. Norris represented the Medical Association of Georgia at the ground-breaking.

1958 Annual Session

April 27-30, 1958—Macon, Georgia



Second Call for Scientific Papers

All titles must be submitted to the respective program chairmen listed below before
November 1, 1957.

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Elmer Lee Fry, M.D.
781 Spring Street, Macon

DIABETES

Harold A. Ferris, M.D.
340 Boulevard, N.E., Atlanta

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781 Spring Street, Macon

INDUSTRIAL SURGERY

Joseph L. Kurtz, M.D.
663 W. Peachtree Street, N.E., Atlanta

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Haywood N. Hill, M.D.
46 Fifth Street, N.E., Atlanta

OBSTETRICS AND GYNECOLOGY

Jule C. Neal, M.D.
203 Professional Building, Macon

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F. P. Calhoun, M.D.
478 Peachtree Street, N.E., Atlanta

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Walter Barnes, Jr., M.D.
724 Hemlock Street, Macon

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Leonard H. Campbell, M.D.
Macon Hospital, Macon

PEDIATRICS

Edwin R. Watson, M.D.
745 Pine Street, Macon

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J. R. S. Mays, M.D.
700 Spring Street, Macon

RADIOLOGY

W. H. Somers, M.D.
Macon Hospital, Macon

SURGERY

C. H. Richardson, Jr., M.D.
700 Spring Street, Macon

THORACIC MEDICINE

Samuel E. Paton, M.D.
797 Poplar Street, Macon

UROLOGY

Charles Rieser, M.D.
819 Cypress Street, N.E., Atlanta

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyrighted, 1957, by the Medical Association of Georgia, 875 West Peachtree Street, N.E., Atlanta 9, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; \$1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.



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COVER

Photo by Ted F. Leigh, M.D. Senator Richard Russell addresses the crowd at the Crawford W. Long Museum dedication ceremonies.

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MAG 1957-58

COMMITTEE ACTIVITIES

SOME 18 MEDICAL ASSOCIATION OF GEORGIA Committee Chairmen met last month on the occasion of the "MAG Chairmen Mid-Year Report meeting." First Vice-President T. A. Peterson presided as each committee chairman reported on the activity and future plans of his particular committee. Because the progress of the Association is entirely dependent on committee achievement, a brief report of committee activity as related by committee chairmen is given here to better inform the membership.

Geriatrics—After a report on the recent Tampa, Florida, Geriatrics meeting, the committee is working on the project of possible federal and state aid to establish convalescent homes basically sponsored and run by each local community.

History and Vital Statistics—A chronological history of the profession and Georgia medicine is being prepared in manuscript form.

Insurance and Economics—Georgia Plan voluntary prepaid insurance revision reported and progress in administering MAG-St. Paul Mercury Professional Liability program given. Future activity concerns major medical and catastrophic insurance.

Physician-Lawyer Liaison—Committee working on a joint code for physician-lawyer relationships with Georgia State Bar Association Committee.

Industrial Health—Committee work centers on proposed revision of present Workman's Compensation Fee Schedule and further study of present Workman's Compensation Law in regard to selection of Physician.

C. W. Long Memorial Museum—Committee responsible for maintainance of C. W. Long Memorial Museum at Jefferson, Georgia and plans to make this site meaningful historical landmark.

Cancer—Committee working with the Cancer Society and the State Department of Public Health in development of Tumor Registries on a statewide basis and also entering into a statewide study on exfoliated cytology program.

Hospital Relations—Committee plans to establish better liaison with the Georgia Hospital Association, Hospital Governing Boards Association and Hospital Medical Staffs. An educational program of setting minimum hospital standards for 25 bed and under hospitals is contemplated. Activity is in progress on hospital indigent care program and paramedical personnel recruitment for hospitals is under study.

Eyecare of the Newborn—This committee advises the State Department of Public Health and is presently investigating the Retrolental fibroplasia problem with its educational aspects and also other drugs than silver nitrate in eyecare of the newborn treatment.

Blood Banks—The committee is surveying the blood bank situation in the state of Georgia and gathering data from the Red Cross, Department of Public Health and Georgia Association of Blood Banks. The committee will then make recommendations based on this study.

Medical Civil Preparedness—This committee serves as advisory to Georgia Civil Defense and transmits data to physicians on all phases of the CD program. The AMA working with this committee advises the FCDA. To this end a regional meeting of chairmen of seven Southeastern Medical Associations CD committees recently met with the AMA Council on National Defense to reappraise the problems of Medical Civil Preparedness.

Public Service—Projects of the Public Service Committee include Auto-Highway safety; Emergency call systems for all Georgia communities; Annual MAG Press Awards; Weekly newspaper health columns written and distributed by MAG; Speakers Bureau; Membership Information Booklets; Fair exhibits; etc.

Scientific Awards—The committee has provided space at the 1958 Annual Session for Scientific Exhibits and will give Association awards for the best exhibits shown by Georgia physicians. Ample space has been allocated and the committee hopes to procure view boxes for use by exhibiting physicians.

Mental Health—The Committee on Mental Health has cooperated with a Study Committee on Mental Health established by the Georgia General Assembly. The Committee is planning a program of working with the Milledgeville State Hospital, the State Department of Public Health and the use of psychiatric beds in general hospitals.

Legislation—The Committee has already had several meetings for methods of informing the members in regard to pending state and national legislation of interest to the physician. In addition to the five members of the Committee, an Advisory Committee of ten physicians, one from each congressional district, has been established.

Ministerial Liaison—This Committee furnished speakers to civic groups over the state to talk on medico-religious subjects. The committee urges physicians to cooperate more closely with ministers in the counseling of patients, etc.

Veteran Affairs—This Committee has three projects: Revision of the fee schedule under the veterans home town care program, completion of a survey of veterans hospital facilities in Georgia and furnishing information to congressmen on veterans problems.

FROM THE A.M.A. WASHINGTON OFFICE

ANALYSIS OF H.R. 9467

Social Security Amendments of 1958

Purpose: To amend the Social Security Act, to increase benefits under the old-age, survivors, and disability insurance programs, and to provide insurance against hospital and surgical services for persons eligible for retirement benefits.

Provisions: This bill contains three major revisions of the present Social Security Act. It would (1) initiate hospital, nursing care and surgical payments for persons eligible for retirement or survivorship benefits under OASI; (2) increase the earnings formula under which persons would be taxed up to the first \$6,000 of earnings (present limit is \$4,200); and (3) increase dollar benefits payable to workers, their dependents, and survivors. The author estimates that under this proposal 12 or 13 million persons could receive medical protection payments in the first year. He stated on the floor of the House following the bill's introduction—"I am grateful that President George Meany of the AFL-CIO has endorsed my proposed amendments as necessary, sound, and enlightened."

Those eligible for such benefits include persons receiving OASI benefits or persons eligible for such benefits; this includes both the retired workers and any of their beneficiaries and survivors *but not those entitled to disability benefits.*

The proposed medical benefits would pay the cost of hospital care for 60 days in any year in semi-private accommodations and nursing home care up to a combined total of 120 days in a twelve-month period. Financed also would be the cost of necessary surgical care (not elective surgery) with freedom to choose a surgeon of the beneficiary's choice, provided the surgeon is certified by the American Board of Surgery or is a member of the American College of Surgeons (except in cases of emergency). For oral surgery the patient would also be privileged to select a duly licensed dentist of his choice.

Hospital care could be received only in those hospitals which had entered into an agreement for payment with the Government. Eligible nursing homes would be only those where skilled nursing care could be obtained and which were operated in connection with a hospital or in which nursing care and medical services are prescribed by, or performed under the general direction of persons licensed to practice medicine or surgery in the state. Necessary minor surgery or surgery in case of emergency would be permitted in a doctor's office.

Physicians would be paid in such amounts as prescribed in regulations promulgated by the Secretary of HEW. Agreements with hospitals would be made with any such institution other than a tuberculosis or mental hospital, provided it is licensed as a hospital or nursing home pursuant to the law of the state in which it is located. Such institutions would not receive payment if payment were due under a workmen's compensation law or plan of any state or the United States. In the event the OASI Trust Fund would pay for hospital and other medical services and where subsequently it is determined a workmen's compensation or other state or federal plan is liable for such expenses, then the United States would be subrogated to all rights of the

beneficiary or the provider of services to whom payment had already been made. The Secretary of HEW could utilize the services of private nonprofit organizations which: (a) represent qualified providers of hospital, nurse-home, or surgical services, or (b) operate voluntary health insurance plans. These nonprofit groups could be utilized as fiscal agents; but only to the extent that the Secretary of HEW "can make satisfactory arrangements with them and to the extent he determines that such utilization will contribute to the effective and economical administration of this section."

A National Advisory Health Council would consult with the Secretary of HEW. The Council would consist of the Commissioner of Social Security, who would serve as chairman *ex officio*, and eight members appointed by the Secretary (four persons outstanding in the field pertaining to hospital and health activities and the other four members to represent the consumers of hospital, nurse-home, and surgical services).

The medical benefits under this proposal would be in addition to the dollar retirement or survivor payments already provided for in the law. For example, a retired worker requiring 20 day's hospitalization and 100 days of nurse-home care in a twelve-month period could, during all of that continuous stay, receive his bed, board and complete medical and subsistence care and still continue to receive up to a maximum retirement payment of \$151.80 per month.

This bill would increase cash monthly benefits across the board. For instance, future beneficiaries' maximum individual monthly benefits would become \$151.80 instead of \$108.50. Family benefits would be increased so that the maximum monthly benefit could reach \$305 instead of the present \$200.

To finance the cost of this entire proposal, including these additional medical benefits, the bill would increase the base on which wage-earners are taxed from the present \$4,200 to \$6,000. In addition it would increase the present rates of contribution of employees and employers by $\frac{1}{2}$ of one percent *each* in 1959 and the self-employed would pay $\frac{3}{4}$ of one percent more based upon the proposed \$6,000 annual maximum. By 1975 the rate of tax for employees would be $4\frac{3}{4}$ per cent and a like tax would be imposed on their employers for a total of $9\frac{1}{2}$ per cent of wages up to \$6,000 annually. For the self-employed persons the tax would be equal to $7\frac{1}{8}$ per cent on the first \$6,000 of self-employment income (the maximum payment would be \$427.50 annually).

A one per cent increase in the tax rate as here proposed would yield the Social Security Trust Fund approximately \$2 billion annually. Apparently the author estimated the average cost for each of the approximately 13 million persons who would benefit by the proposed health care amendment would be about \$150 annually. To multiply that amount by the number of persons to be benefited would result in a total of approximately \$2 billion. In raising the tax base from \$4,200 to \$6,000, the author proposes to raise sufficient funds to finance the increases in dollar payments for retirement benefits, therefore, the rate increase would be assigned solely to finance the hospitalization and surgical benefits.

THE ELECTROENCEPHALOGRAM IN ANESTHESIA

*A comprehensive review outlining the usefulness and limitations
of the electroencephalogram in both clinical and experimental anesthesiology*

CURTIS PEARCY, M.D., Augusta, Georgia

IN RECENT YEARS considerable attention has been directed toward changes in cerebral electrical activity associated with general anesthesia. The major stimulus for this study has been the work of Courtin, Bickford, and Faulconer in 1950 which showed that ether anesthesia was associated with reproducible changes in the electroencephalogram. Studies on most of the other agents employed in general anesthesia have been made, and many references to electroencephalography have appeared in the anesthesia literature. Because of this interest in electroencephalography, anesthesiologists should understand its application to their specialty.

Any understanding of electroencephalography in anesthesia requires at least an acquaintance with the basic principles of the recording of cerebral electrical activity. The normal discharge of neurones produces minute changes in voltage on the scalp. The areas of the brain responsible for these changes are unknown, but the cortex appears to be the major source. The voltage changes are rhythmical in nature and so produce a regular pattern on moving paper. Figure one illustrates basic frequencies and their appearance in pure form. This figure shows very simply the basic types of tracings encountered. It is readily seen that a rhythmic up and down deflection of a writer point on moving paper will inscribe curves of this sort. Differences in the speed and amplitude of the writer point swing will pro-

duce the different tracings. Even though the tracings are quite different in appearance, each is a product of a similar up and down swing of the writer point. The record is produced in such a way that a larger voltage change will produce a greater excursion of a writer point, and a rapidly fluctuating voltage will produce waves close together. A negative charge produces an upswing of the writer point, and a positive charge produces a downswing.

By tradition the term *alpha* is applied to frequencies of six to 13 per second. Frequencies of resting adults fall in this range. The term *beta* is applied to the range of frequencies between 14 and 50 per second, and the term *delta* to the range between one-half and five per second. Thus an alpha wave is the record of a voltage fluctuation occurring regularly six to 13 times each second. There is nothing which distinguishes an alpha wave from a delta wave except difference in frequency. Furthermore, there is nothing in the encephalogram that is discrete and subject to minute analysis as there is in the electrocardiogram. In the cardiogram a few representative waves may be analyzed in some detail. The encephalogram, on the other hand, requires several minutes or even hours of continuous recording to produce interpretable records.

It is possible to have a mixture of frequencies such as is shown in the lowest line of Figure one. This is a segment of an EEG showing a fast fre-

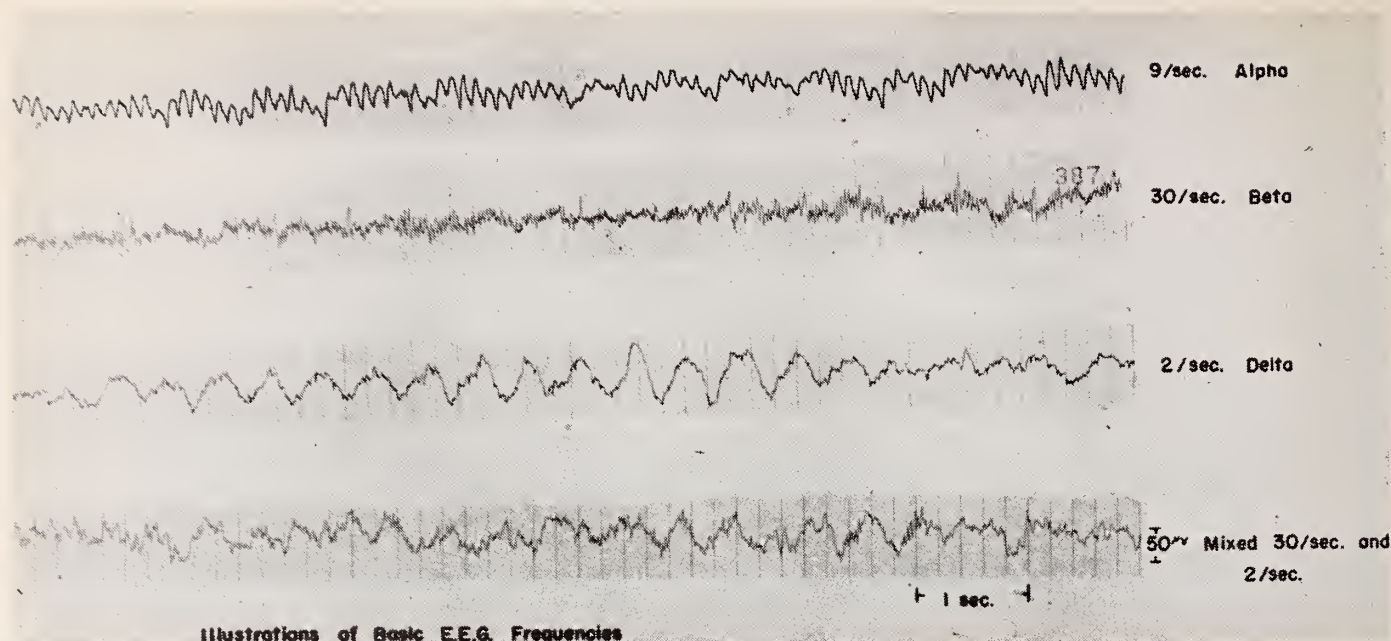


Figure 1: Representative portions of electroencephalograms illustrating basic frequencies.

quency superimposed on a slow frequency. Many of the odd forms seen in an encephalogram result from different frequencies occurring at the same time and being inscribed as the algebraic summation of the two.

The voltage, as represented by height of the recorded wave, is also important and is taken into account in interpreting EEG records. The alpha frequency usually has a voltage of about 50 microvolts. In general, slower frequencies are associated with higher voltage than the fast frequencies. Some of the slow frequencies of moderate anesthesia have an amplitude of 200 microvolts.

The major application of the EEG in anesthesia, so far, has been in the determination of depth of anesthesia. Other uses advocated have been assessing the adequacy of circulation, automatic control of anesthesia, and some other special applications.

The studies of Courtin, Bickford, and Faulconer¹ on ether anesthesia and of Possati, Faulconer, Bickford, and Hunter² on cyclopropane anesthesia showed characteristic, reproducible changes in the EEG as anesthesia was deepened. Recording from fronto-central electrodes, these investigators systematized the changes seen into six levels, as shown in Figure two:

LEVEL I: 20 to 30 per second frequencies of low amplitude. This corresponds to the level of analgesia.

LEVEL II: Regular 200-300 microvolt waves with a frequency of three to seven per second. The characteristic feature of this level is its regularity.

LEVEL III: The complex level, having many mixed frequencies without repetitive forms.

LEVEL IV: Early electrical suppression represented by straight line intervals on the tracing.

This is the beginning of the burst-suppression phase.

LEVEL V: Suppression intervals greater than three seconds but less than 10 seconds in duration. Burst-suppression here is readily apparent.

LEVEL VI: Suppression greater than ten seconds.

These EEG levels have been correlated with blood ether³ and cyclopropane² concentrations. A graph of the EEG level plotted against average blood concentration of agent will give almost a straight line. There is, however, a wide variation from person to person in the blood concentration of agent required to produce any given EEG level. For instance, 100 mgm per cent ether in the blood of one patient may be associated with Level IV, while another patient requires 150 mgm per cent to reach Level IV. This variability is thought to be a result of differences in individual dose response.

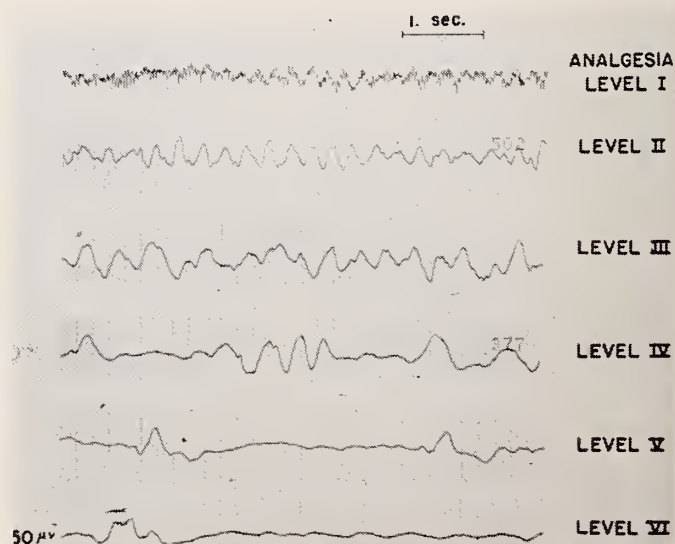


Figure 2: Electroencephalographic changes seen during ether anesthesia (after Courtin, Bickford and Faulconer) recorded from fronto-central electrodes.

Intravenous barbiturates and other intravenous anesthetics act similarly, producing changes like those of ether.⁴ The characteristic feature of barbiturate depression is activity about 30 per second. This fast activity appears before consciousness is lost and is sometimes called pentothal fast activity. It is similar to, but on the whole somewhat faster than, the activity of ether analgesia. With deeper depression the barbiturates produce irregular slow activity and finally burst-suppression. In the classification of barbiturate effects, Level II is similar to Level III ether, and early burst-suppression is termed Level III. Activity similar to Level II ether is not described with barbiturates.

Most other anesthetic agents have been studied, and most potent agents appear to produce a sequence similar to that of ether or thiopental. Impotent agents show variable amounts of slowing. Nitrous oxide supplemented with thiopental produces changes similar to those of thiopental alone. Nitrous oxide supplemented with meperidine, however, produces only slowing without burst-suppression.⁵ A recent report⁶ suggests that trifluorethylvinyl ether may likewise not produce burst-suppression. Therefore it would appear premature to make generalizations regarding EEG changes during anesthesia.

Correlation of EEG level with clinical depth of anesthesia has not been completely successful, nor has it been possible to correlate EEG levels with the Guedel stages of anesthesia. Not infrequently a patient's electrical level is light while by clinical signs he is deeply anesthetized. Similarly the EEG may show adequate depression, while relaxation and operating conditions are unsatisfactory. In general, however, either Level III or IV is necessary for abdominal relaxation with ether although occasionally Level V and rarely VI is necessary. Superficial surgery can be accomplished in Level II or III.

The EEG during anesthesia can be altered by factors other than the anesthetic agent. Hypoxia produces a progressive slowing of the EEG frequency. With hypoxia to the extent of clinical cyanosis EEG frequencies may be as slow as one per second. As death from hypoxia approaches, voltage is lowered progressively until the tracing becomes flat. Changes in carbon dioxide also can alter the tracing. Hypercarbia causes an increase in the basic EEG frequency. Low CO₂ produces effects similar to those of hypoxia, namely, a slowing of frequency. There is some question whether the change in pCO₂ is responsible for the slowing seen with hypocarbia. It may be that the reduction in cerebral blood flow known to accompany low CO₂ causes sufficient tissue hypoxia to produce EEG changes. There is evidence in the literature to support either a direct effect of CO₂ or a secondary effect from diminished blood

flow.^{7,8,9} In any event, the slowing with hyperventilation is well known. Anesthesiologists should note cautiously the changes associated with alterations in carbon dioxide. In anesthesia low oxygen and high carbon dioxide are usually associated together. However, the encephalogram is affected similarly by low oxygen and low carbon dioxide while high CO₂ causes an opposite type reaction; thus, the usual relationship of hypoxia and CO₂ accumulation is exactly reversed.

The EEG has been suggested as a means of recognizing a cardiac arrest. Bellville and Glenn,¹⁰ showed that the brain responds to acute ischemia with high voltage, low frequency electrical activity. If, therefore, a cardiac arrest occurs with resultant cerebral ischemia slow frequency waves appear on the EEG. Further, if myocardial depression precedes the actual arrest, cerebral circulation will be compromised while the heart is still feebly contracting. In this event the EEG will show changes of cerebral ischemia before the arrest occurs and give sufficient warning so that the impending disaster can be averted. The encephalogram may be, therefore, an indicator of approaching cardiac arrest and may provide time for remedial action. These changes in cerebral activity have preceded electrocardiographic evidence of cardiac arrest in some cases. In these cases proper interpretation of EEG findings may be of real value to the anesthesiologist.

In the event that a cardiac arrest does occur and artificial circulation by cardiac massage becomes necessary, the EEG is of continuing value. Truly effective cardiac massage should cause the EEG to revert to more nearly normal, losing the slow activity associated with cerebral ischemia. Failure of the EEG to improve is good evidence that the cardiac massage is ineffective, and unless improvement can be made the patient is not likely to be saved.

A major application of the EEG has been in anesthetic research. The EEG provides a quantitative basis for comparing a new drug to other similar drugs already in use. In the past few months most reports of new drug studies have included EEG records made in the course of use of the drug. A better understanding of the new drug is thus made possible. Fundamental research on the mode and site of action of anesthetics is being furthered by electroencephalographic data. Also, the EEG has provided a standard reference of anesthetic depth for all investigators. Prior to introduction of the EEG into anesthesia, quantitative comparisons of anesthetic depth were not readily obtained. With this control now available, results of different laboratories can be correlated more closely.

Certain special applications have been found for encephalography in anesthesia. The automatic con-

ELECTROENCEPHALOGRAM / **Pearcy**

trol of anesthesia is at present a rather special application. EEG data are the basis of operation of the servomechanism used in automatic anesthesia. The servomechanism utilizes some feature of the EEG to maintain smooth anesthesia. The basic structure of these instruments is exemplified by the mechanism for thiopental.¹¹ During thiopental anesthesia a frequency of 12 per second varies appropriately to activate a servomechanism. All other frequencies are filtered out electrically, and the 12 per second frequency is fed into an electronic integrator. Through a complex series of circuits this 12 per second activity is made to regulate the injection of thiopental. As 12 per second activity increases more thiopental is injected. The thiopental depresses the 12 per second activity so that less thiopental is given. An equilibrium is soon established and appropriate amounts of drug are administered steadily. Similar devices have been constructed to administer ether and cyclopropane. The basic circuits of all these devices were described by Bickford.¹²

Difficulties in the use of servomechanisms arise from the very complexity of the instrument itself and from the fact that the instrument must be calibrated empirically for each patient. This calibration has been accomplished only by trial and error adjustment. In centers where the apparatus is available it is useful in such procedures as prolonged operations or prolonged heavy sedation such as is used in the management of tetanus. Servo-anesthesia is also useful in investigative work in the laboratory. Its full clinical potential is not yet established.

In other special situations EEG changes can provide useful information. Inadequate ventilation can be suspected by changes in the EEG. Changes indicative of hypoxia might be progressive slowing of frequency when no additional anesthetic agent has been administered. Cerebral circulation might be impaired by surgery about the great vessels. This impairment would result in EEG changes like those seen in cardiac arrest. Upon seeing these changes the anesthesiologist would be justified to ask the surgeon to modify his approach. Evaluation of prolonged post-anesthetic recovery also may be assisted by EEG changes. These examples are representative of some of the ways in which electroencephalography may help the anesthesiologist.

Practicing anesthesiologists are concerned about the value of electroencephalography to them in their day to day management of patients. A recent advertisement in a leading anesthesia journal was headed, "Now you can be certain of your patient's depth," implying that the EEG instrument advertised would give the anesthesiologist this absolute information. If depth can really be determined with this

certainty and without error, each anesthesiologist should have the instrument. If on the other hand the claims are a bit extravagant, the anesthesiologist may or may not need the instrument. To evaluate such claims one must critically examine them and their basis.

How good is the EEG in indicating depth of anesthesia? The scheme of EEG levels presented earlier represents the major effort to classify and categorize anesthetic depression by EEG changes. This sequence of changes is thought to be valid and its relationship to progressive central nervous system depression with most agents is accepted. Further, these changes usually are readily interpretable. This briefly represents the black ink side of the ledger. Unfortunately there is some red ink as well.

As has been mentioned, EEG depth is a rather poor guide to clinical adequacy of anesthesia. Relaxation of the abdominal musculature is poorly correlated with EEG level if it can be correlated at all. Further, as any clinician might well expect, the EEG of some patients does not follow the standard sequence of changes. Lesser variations of frequency and voltage are common and can be confusing. Major deviations from standard responses are also seen. In some patients deep anesthesia with depressed respiration, fixed eyeballs, dilated pupils, and deterioration of blood pressure occurs without burst-suppression appearing on the EEG. Ordinarily burst-suppression should appear in moderate anesthesia. Fortunately this extremely unusual response is infrequently seen. The proper interpretation of these variations is sometimes difficult and can be made only in retrospect.

It must be remembered that depth of anesthesia is not a simple unity. Depth is related to many systems of the body and can be influenced by many variables. Cerebral depression is but one part of the complex response of the body to anesthesia, and cerebral depression is the only part of this response directly measured by the EEG. The anesthesiologist must correlate the cerebral depression with his clinical observation of the patient in order to arrive at a truly valid impression of anesthetic depth.

The practitioner would probably find little occasion to use the EEG for purposes other than estimation of depth. The possibility of detecting cardiac arrest is intriguing, but a finger on the pulse is a simple indicator of this event. Further, the cautious anesthesiologist rarely meets a cardiac arrest. Surgery of magnitude sufficient to compromise cerebral circulation would be equally rare even in a busy practice of anesthesiology. Automatic anesthesia, too, is still a long way from being readily applicable to ordinary circumstances.

What, then, is the usefulness of the encephalogram

to the anesthesiologist? The EEG is an additional tool providing data related to cerebral activity. Its changes, properly interpreted, can indicate whether a brain is lightly depressed, moderately depressed, or deeply depressed. The cause of the depression often cannot be determined from the EEG changes. The EEG may in extraordinary circumstances provide the basis for information not otherwise available. Used as an aid to clinical evaluation it can provide evidence to support clinical judgment of the anesthesiologist. The EEG may provide helpful information but is not the panacea of anesthesia.

Medical College of Georgia

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OPEN DOORS TO FOREIGN MEDICAL STUDENTS

THE United States helped meet the world's need for better medical care last year when more than 6700 foreign interns and residents from 88 countries around the world trained in American hospitals, according to a survey recently released by the Institute of International Education. Of this group, 4753 served as residents and 1988 trained as interns in hospitals throughout the United States.

An increase of the ten per cent over the previous year, the substantial rise was due chiefly to the greater number of young physicians coming here from the Far, Near, and Middle East. More than two-thirds of these doctors traveled from these areas and Latin America, reflecting the deep need in these countries for improved medical care and the lack of local training facilities.

Medical men, as usual, outnumbered medical women. Only 908 (13.5 per cent) of the total group were women, with the Philippines sending more women proportionately than any other country.

In seeking the top-calibre medical training available in the United States, these young medics were scattered throughout forty-four states, the District of Columbia, Hawaii, and Puerto Rico. However, most of them (75 per cent) were concentrated in ten states, with one-quarter of them in New York State hospitals, and one-half of them in hospitals in Ohio, Illinois, Massachusetts, Pennsylvania, New Jersey, Missouri, Maryland, Michigan, and Texas.

The four hospitals with the largest group of foreign interns and physicians were Bellevue in New York City,

Boston City in Boston, Medical Center in Jersey City, and Henry Ford in Detroit.

The IIE survey, called "Open Doors" and conducted annually to determine the number of foreign students, physicians, and scholars studying in our country, also reported 3854 foreign students studying in the various medical sciences—dentistry, medicine, nursing, pharmacy and pre-medical studies in United States colleges and universities. This represents about nine per cent of the total number of foreign students (40,666) in the United States for 1956-57.

The "Open Doors" survey also reported on the number of American students studying medicine abroad during the 1955-56 year, with the largest concentrations in Europe and Canada. Of the 996 students from the United States studying in Switzerland, 669 were in the field of medicine. 319 Americans were pursuing medical studies in Italy and 174 in the Netherlands. 293 went to Canada.

The number of foreign and American medical faculty members who participated in the exchange movement last year were relatively small. 180 foreign medical scholars came to the United States and 81 American faculty members in the field of medicine went abroad. The latter figure, however, represents and almost 100 per cent increase over the 45 American medical faculty personnel who went abroad the preceding year. This increase could be indicative of a trend on the part of the American medical profession in establishing medical exchange as a two-way road.

GLAUCOMA IN GENERAL PRACTICE

A comprehensive review of the problem is presented. A plea is made for the routine screening of patients in the middle and older age groups by physicians carrying out general physical examinations.

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ABOUT 2,000 OF THE approximately 3,750 doctors of Georgia are in their late thirties or older. There are probably forty of these in active practice who have undiagnosed glaucoma and are losing vision each day. Glaucoma is responsible for one-eighth or twelve per cent of all blindness. It is estimated there are 42,000 totally blind Americans from glaucoma. Many more are partially blind¹. The annual incidence of new cases seems to be increasing. The group of particular interest in this discussion is the large group of Americans with undiagnosed glaucoma.

The disappointment and personal problems of being blind cannot be estimated. Also, the annual cost of service to the blind from public funds and private endowments is considerable. The national cost is in excess of \$125,000,000². In the state of Georgia the annual cost of care for the blind during the past year was \$576,550.50 in addition to more than a million dollars from Federal assistance.³

When the ancients first used the word glaucoma, they referred to a reddened, hardened, completely blind eye with a bluish-green appearance of the iris. Modern knowledge of glaucoma began about a century ago with the invention of the ophthalmoscope. The period of study which interests us most is the last fifteen years.

Instead of diagnosing glaucoma for a blind eye we must try to make the diagnosis when normal vision is present. This includes the visual acuity and peripheral vision. When diagnosed early and treatment continued, the prognosis is far better than when treatment is started in a later stage.

About two per cent of us over forty years of age probably have glaucoma or will develop it. A large scale glaucoma screening program was conducted in Philadelphia from 1944 through 1950 to determine the incidence of undiagnosed cases.⁴ Ten thousand industrial employees between the age of 40 and 65 were examined. An incidence of two per cent of these 10,000 was found to have previously undiagnosed

glaucoma. If older people had been included, the incidence might have been higher.

A screening project was conducted in Cleveland in 1953 and 12,803 persons over 40 years of age were tested for elevated intraocular tension.⁵ An incidence of slightly less than two per cent was found. Other surveys have reported from one per cent to five per cent. The advantages of these surveys are that early cases can be found, the public educated to the fact that glaucoma exists as a preventable cause of blindness, and the incidence of undiagnosed cases can be estimated.

The average age of onset of blindness from chronic simple glaucoma is between 60 and 65. This would indicate the disease had its start while the patient was ten or twenty years younger. Since life expectancy has increased from forty-five to sixty-five during the past half-century, many more people are surviving to an age susceptible to glaucoma blindness.

Chronic simple glaucoma occurs about four times as often as the other types which will be mentioned only briefly.

Acute congestive glaucoma as its name implies is an acute process. An attack occurs when the iris blocks the angle of the anterior chamber of the eye (Fig. 1). This is likely to occur in the eye with a narrow angle. The attack consists of dilation of the pupil, deep pain in or around the eye, hardness of palpation, steaminess of the cornea from edema, excessive lacrimation, and possibly edema of the lids. Impaired vision results from the edematous cornea and increased intraocular pressure.

Such an attack is to be differentiated from sinusitis, iritis, or conjunctivitis. In sinusitis evidence can usually be seen in the nose. In iritis the pupil is small and the eye feels normally soft. In conjunctivitis the pain feels scratchy or like sand in the eyes, the pupils react to light, and vision is usually not affected. Vomiting and nausea may occur and in

some cases attention has been centered on the abdomen rather than acute glaucomatous eye. This is the dramatic attack which is a real emergency.

Secondary glaucoma as its name implies occurs secondarily to some other process. This is more likely to be found when the iris angle is narrow. Contributory factors are swelling of the lens, uveitis, exfoliation of the equatorial capsule or Zonule fibers, complications following cataract extractions or disorders of the iris. The symptoms and signs are much like acute congestive glaucoma.

Congenital glaucoma is one of the principal causes for admissions to the schools for the blind. It may be present at birth or soon after. Severe cases are obvious with steamy corneae. The less conspicuous may have only photophobia and lacrimation. When these two symptoms are present in a baby, congenital glaucoma should be suspected.

Chronic simple glaucoma has an open iris angle (Fig. 1). This is the most common type and develops gradually and insidiously. "Thief in the Night" and such terms have been given it. The patient may lose considerable side or peripheral vision before being aware of the loss. An outstanding feature is the lack of symptoms. The diagnosis must usually be made by the doctor without any assistance from the patient. Since the patient cannot offer help, it is the responsibility of the physician to be alert to the signs of glaucoma.

Kronfeld has said that diagnosis of early chronic simple glaucoma is made on suspicion. All adults 35 to 40 years of age and over should be suspected of glaucoma until proved otherwise.

Fortunately, many patients have recurrent headaches as an early symptom and seek their family doctor for relief. The headaches are not typical and

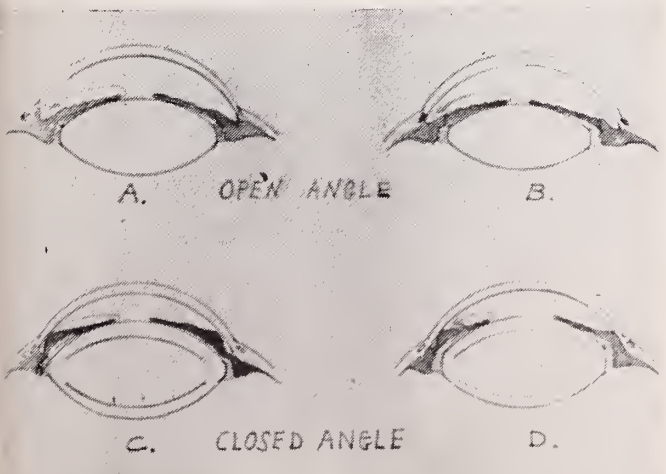


Figure 1: A. Open iris angle and Schlemm's canal mechanism. Arrows indicate flow of aqueous from posterior chamber through pupil into anterior chamber and out through Schlemm's canal mechanism. B. Schlemm's canal mechanism blocked. (Chronic simple glaucoma.) C. Narrow iris angle. Shallow anterior chamber, aqueous outflow is adequate most of the time. D. Iris angle block from dilatation of the pupil. Schlemm's canal mechanism open.

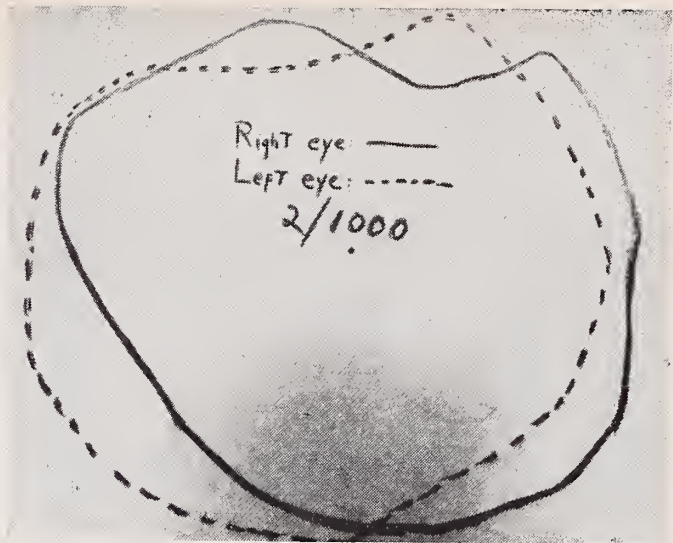


Figure 2: A. binocular field of vision. Shows extensive duplication of fields of vision.

can be easily mistaken for chronic sinusitis, migraine, or tension. They are often confused with refractive errors and the glaucoma patient may speak of frequently changing glasses without benefit. Headaches associated with blurred vision and haloes are especially suspicious. Haloes can be seen early in the course of the disease when transient increased pressure affects the cornea but this is not the rule.

The earliest sign of chronic simple glaucoma is an elevated intraocular tension. If a test is not made for this finding, it can easily go unnoticed. The second change to take place is a constriction or loss of peripheral vision with various scotomas. Vision of 20/20 gives no information on the presence or absence of early glaucoma. Some patients can have good visual acuity with gross peripheral field defects. The patient is not aware of an early change. The first area of the retinal periphery to become involved is the lower temporal area which corresponds to the upper nasal field of vision. This portion of the visual field is also included in the upper visual field of the fellow eye. Since one eye is usually more advanced than the other, much loss can be suffered before the patient is aware of it (Fig. 2).

The National Society for the Prevention of Blindness, 1790 Broadway, New York 19, New York, has long been on the job of combating glaucoma and other forms of blindness. More recently The Ophthalmological Foundation, Inc., 111 East 59th Street, New York 22, New York, has begun an active glaucoma research project. Currently 606 ophthalmologists are cooperating as preceptors. Thirty eight medical schools and 5,500 general physicians and medical students have received instructions in "screening" patients for glaucoma. The tone or tension of the eye is measured with a tonometer (Fig. 3). The instrument devised and distributed by the Foundation is the Berens-Tolman Ocular Hypertension

Indicator. This is not as accurate as the Schiotz tonometer but is simpler. It reveals to the examiner if the intraocular tension is essentially within normal limits, above normal or below normal.

The tonometry technique is simple, requires about

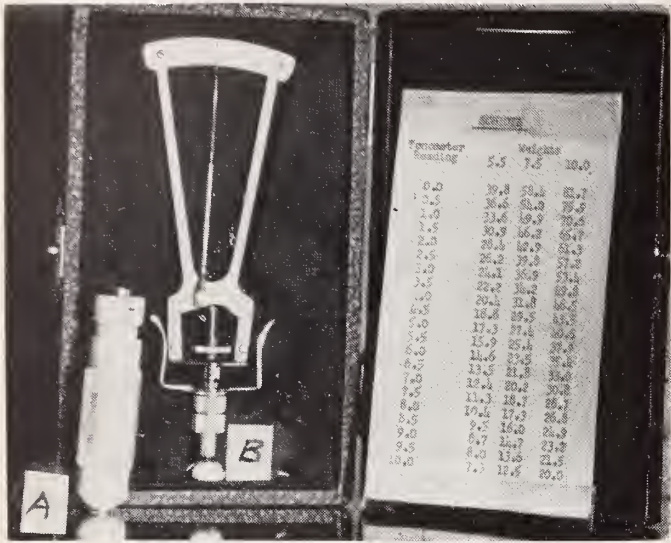


Figure 3: Berens-Tolman tonometer. B. Schiotz tonometer.

three minutes, and should be done in every diagnostician's office. One of the advertised and well known ophthalmic solutions is used for topical anesthesia. Among the most popular are Ophthaine, Pontocaine, Dorsacaine, Butacaine, or Tetracaine. The patient should relax in a reclining position and look directly above at the ceiling or hold his hand upward and look at it. The tonometer is held in a vertical position



Figure 4: Berens-Tolman tonometer.

and lowered to permit the foot plate to rest on the central portion of the cornea. The Berens-Tolman tonometer is read directly (Fig. 4) and the Schiotz tonometer (Fig. 5) is read and interpreted from a

graduated scale. The tonometer should not move across the cornea as the cornea could be easily abraded.

If a physician is without a tonometer, digital palpation through the eyelids is better than no test at all. This is not much better than looking at automobile tires to determine if the air pressure is correct. This will at least keep the doctor mindful of the possibility of glaucoma. The confrontation test of facing the patient and trying to determine the peripheral field is good only for detecting large field defects. This would not help in early diagnosis. Tonometry is the best and easiest test for screening cases.

When glaucoma is diagnosed or suspected, every effort should be made to get the patient under competent medical supervision. It should be remembered that each day lost between the time of onset of the disease and the beginning of treatment can be detrimental to the visual prognosis.

The experience of most ophthalmologists today is an increased finding of total glaucoma cases and a decrease in total glaucoma operations. This indicates a trend toward earlier diagnosis and more careful administration of improved miotics.

It is not intended to describe the details of therapy but pilocarpine is still the time honored miotic of greatest reliability to improve aqueous outflow.⁶ Other miotics have their special indications. Diamox is a new antiglaucoma drug which decreases the production of aqueous. It is a great

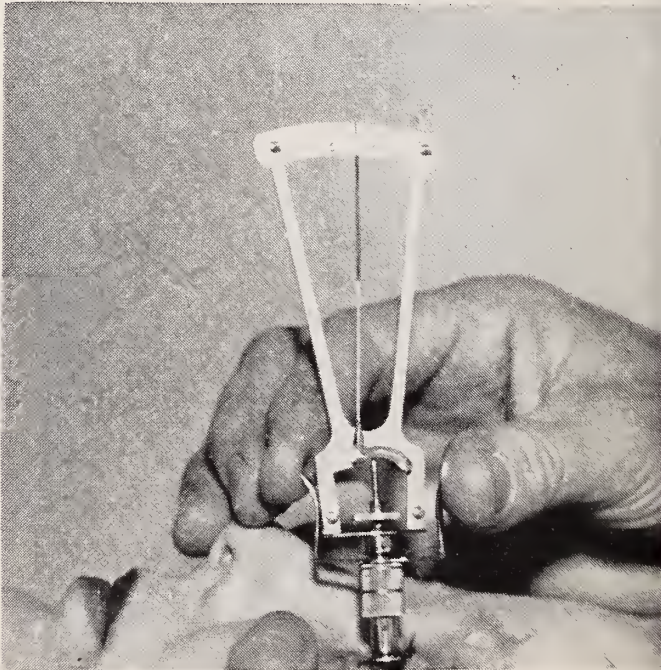


Figure 5: Schiotz tonometer.

addition to the use of miotics but is not recommended as a substitute.

When medical care fails to keep the tension normalized or the fields from becoming smaller,

surgery may be indicated. The age of the patient and the extent of glaucoma damage influences one's judgment concerning surgery. Opinions of our best specialists range from a statement that surgery for glaucoma is a confession of ignorance to another that diamox may be treacherous because it may deprive the patient of the opportunity of having surgery performed. The aim of surgery is to establish drainage channels for the aqueous. Best results can be expected when the disease is not far advanced. When considerable field loss has occurred the loss is prone to progress in spite of surgical normalization of the tension.

All forms of treatment for glaucoma are unusual in that they are aimed at the results and not the cause. Miotics and surgery are intended to lower the intraocular tension. Treatment should be early and must be continuous. Although we do not know the predisposing causes of chronic simple glaucoma, we do know that if neglected the victim will lose sight permanently because of the continued pressure on the retina and the optic nerve head.

It is important that all patients over forty have their ocular tension tested at least every two years. The optometrists do more than half the refractions for the public. Credit must be given the optometrist who refers the patient with sub-normal vision to the ophthalmologist but the presence of sub-normal vision is regrettable. The physician should refer his patient to an ophthalmologist if help is needed for eye care.

A large increase in glaucoma research has taken place within the last fifteen years. A slight increase of optimism has occurred principally because of the ability to measure the rate of flow of aqueous through the chambers of the eye. This is called tonography which is actually sustained use of an electric tonometer.

With the increase in glaucoma research there has also been an increase in clinical alertness to diagnose early cases. The ophthalmologist keeps glaucoma in mind and with careful routine use of the ophthalmoscope, tonometer, and probable use of the tangent screen or Harrington multiple screen test, more and more new cases are found. The water drinking test is the most reliable for additional information in wide angle or chronic simple cases.

The patient with early simple glaucoma needs detailed instructions and encouragement. He should be greatly encouraged over his early diagnosis. He should try not to worry. Daily living habits may be

continued but he should faithfully use his eye drops. They are no more bothersome than the daily use of the tooth brush, lipstick, or shaver. Appointments must be kept with the doctor. Excessive drinking of fluids should be avoided. One cup of strong coffee is better than two weak cups.

Summary

An appeal is made for all physicians to share the responsibility of diagnosing glaucoma. Routine tonometry is recommended.

The distressing features are the insidiousness and relentlessness of this disease.

The onset usually occurs during a period of life when many confusing factors are present. The multiple causes of recurrent headaches can make the examiner forget the incidence of glaucoma. This incidence seems to be increasing beyond the two per cent estimates of surveys a few years ago.

Early diagnosis is the best weapon for treatment. With earlier medical care and improved miotic solutions, there is a note of increased optimism for the glaucoma patient. In many early cases the patient is symptom free. Tonometry is simple and can be done by all physicians.

The general practitioner can benefit the glaucoma patient greatly. He can diagnose early. He can give encouragement, especially over an early diagnosis. He can recommend a continuation of the patient's usual living habits with faithfulness in using the eye drops and avoiding excessive fluid intake.

Physicians are urged to secure more information on glaucoma. A tonometer for screening purposes can be purchased for twelve dollars from the Ophthalmological Foundation, Inc., 111 East 59th St., New York 22, New York. This organization and the National Society for the Prevention of Blindness, 1790 Broadway, New York 19, New York, will furnish helpful literature upon request.

959 Daisy Park

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DO YOU KNOW?

SPENDING FOR HOSPITAL services has gone up 79 per cent over the past ten years while the costs of physi-

cians' services have advanced only 33 per cent, according to the Social Security Administration.

HYDATIDIFORM MOLE

Five Case Histories

Diagnosis, therapy, and follow-up are discussed in both hydatidiform mole and choreocarcinoma.

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VESICULAR DEGENERATION OF THE chorion known as hydatidiform mole is a conception that compresses in its half life of gestation all of the complications of the normal length pregnancy. Unfortunately, these complications may become catastrophic in a molar pregnancy, and in a given case may end with the most malignant of all neoplasms, the chorioncarcinoma. The three conditions of toxemia, hemorrhage, and infection causing the morbidity and mortality of the usual pregnancy may appear in their most advanced state in hydatid mole.

This pathological entity was first mentioned in the sixth century A. D., but not until the 19th century A. D. was this condition described by Marchand as trophoblastic proliferation. The reported incidence is 1:145 to 1:3000 live births. If hydatidiform degeneration in all aborted ova is taken into consideration, four per cent of all pregnancies are of molar type. Asiatic races have the highest incidence, and molar pregnancy is more frequent in multiparas and in women past the age of forty years. There are a number of cases in women past fifty years of age, and Moore¹ reports a case in a patient fifty-three years old. The odds that a patient will have a repeat molar conception with the next pregnancy is variously reported by Posner² as one in 50 to one in 127. Logan³ reports a hydatidiform mole in conjunction with a living fetus. Fewer than a dozen such cases have been recorded. One of the five cases in this present report is a near-term living fetus with a hydatid mole in conjunction with normal placental tissue.

A chorionepithelioma develops in two per cent of cases of hydatidiform mole. However, in cases of chorionepithelioma 50 per cent have had a previous molar pregnancy. Polycystic change of the ovaries occurs in 25-60 per cent of hydatid mole and chorionepithelioma. These are lutein cysts and they store the chorionic gonadotropic hormone in their fluid. Fortunately, these cysts retrogress after the complete evacuation of the mole. These abnormal pregnancies are of great interest in the concept of fetal tumors growing in the homologous maternal

host. Dowling⁴ writes there is a dedifferentiation of the tumor or an antigenic simplification which holds in check the building up of the anti-body defense of the host. Some of the tumors survive because of genetic identity.

The diagnosis of hydatidiform mole is rarely made before passage of some of the characteristic "grapes." However, a high index of suspicion will help in making the diagnosis along with the following points. Bleeding is the presenting symptom starting usually between the third and fourth month. In 50 per cent of cases the uterus is larger than it should be for the length of gestation. In the remainder the uterus is of normal size or smaller. The incidence of nausea and vomiting is no greater than usual but may be much more severe. There may be clinical features of pre-eclampsia and eclampsia. There is a rapid onset and progression of albuminuria, hypertension, and edema. This is, of course, much earlier in pregnancy than usual. Severe anemia may develop quickly due to constant and profuse blood loss. X-ray may or may not be of value except in very late cases where no fetal skeleton is seen. No fetal heart tones can be auscultated in these late cases. Biologic tests are only of limited value in diagnosis but are of great value as a follow-up after the evacuation of the mole.

The following five cases presented in summary occurred between January 1, 1955, and June 30, 1956, in our private practice at St. Joseph's Infirmary. During this time interval there were 2,611 deliveries by various members of the staff that had passed 28 weeks gestation. There were six molar pregnancies during this same time including the ones presented in this paper. This gives an incidence of one in 435.

Case Reports

Case No. 1: C.B.D.; 28 years old; gravida one with last menstrual period July 9, 1954; began vaginal bleeding in December, 1954, and was admitted to hospital for two weeks. No fetal heart tones were auscultated and no fetal movements were

felt. Hydatidiform mole was suspected but not proved. Decision was made to give more time for observation. Patient was readmitted on 1-5-55; still no fetal movements; no fetal heart tones auscultated; X-ray negative for fetal skeleton. The uterus was the size of a three months pregnancy, being smaller than on previous admission. A frog test was positive. It was thought that either a missed abortion had occurred or a molar pregnancy was present. On 1-5-55 patient was given 500cc. 1:1000 pitocin solution I.V. without result. At 6 p.m. that night patient was given 60,000 units theelin in oil in three divided doses two hours apart. At 5:30 a.m. 1-6-55 patient spontaneously passed a hydatidiform mole with 200cc. blood loss. D & C done immediately and pathologist returned a report of benign mole. Post abortal course uneventful. Chest X-ray was negative. Frog tests done at regular intervals and all negative. Pelvis negative after one year and patient pregnant with normal gestation after 18 months.

Case 2: M.G.; 26 years old; Gravida one with last menstrual period April 27, 1955; began bleeding July 5, 1955, and had vaginal spotting every day until August 29, 1955, when bleeding became profuse with cramping and patient was admitted. One hour after admission patient passed a "bunch of grapes." D & C was then done and one whole blood transfusion given because of blood loss of 500cc. Pathology report was benign mole. Post abortal course was uneventful. X-rays of chest were negative. One year follow-up with frog tests was negative and pelvis was normal after one year.

Case 3: J.F.R.; 32 years old; Gravida three, Para one, Abortion one; last menstrual period May 2, 1955; began spotting per vaginum July 2, 1955. This bleeding continued until August 4, 1955, when it became as profuse as a menstrual period part of each day. Hemoptysis noted at this time with onset of slight cough. On September 5, 1955, patient passed a "quart of something that was not real blood" and was then admitted to hospital and examined. Material was a typical hydatidiform mole. D & C was done immediately and transfusion of whole blood (500cc.) given because of 450cc. blood loss. Pathologist reported molar pregnancy with hypertrophy of trophoblastic elements and occasional atypical large hyperchromatic nuclei. Post abortal course was uneventful and chest X-rays were negative. However, hemoptysis continued and two frog tests were still positive October 3, 1955. There was no vaginal bleeding. On October 8, D & C and bronchoscopy (Dr. Bedford Davis) were done. Pelvis grossly negative. Pathology report revealed Class V hydatidiform mole, (Dr. Walter Sheldon consulted in diagnosis). The bronchial washings were negative for tumor cells. On October 19, 1955,

a total hysterectomy and bilateral salpingo-oophorectomy done. Pathological report revealed a one cm. mass of tissue in wall of uterus that microscopically was chorioadenoma-destruens. There were numerous small lutein cysts in ovaries. Patient did well until January, 1956, when a bluish mass was noted in vagina near urethra. This was removed January 19, 1956, and found to be metastatic choriocarcinoma. X-rays of the chest demonstrated numerous one to three cm. metastatic lesions in the lungs. On January 27, 1956, patient developed a right hemiplegia of sudden onset associated with right-sided pain, and X-rays revealed even more numerous metastatic lesions of lungs. Nitrogen mustard was given intravenously (six mg. every other day I.V. for four doses) with much associated nausea and no improvement. Testosterone 200 mg. per day was given. The course was downhill with hepatomegalia and ascites and patient died at home on February 27, 1956. No autopsy done.

Case 4: B. T.; 26 years old; Gravida two, Para one with last menstrual period February 2, 1955, and due November 9, 1955. Had uneventful pregnancy but went into spontaneous labor three weeks before term and delivered on October 14, 1955 a normal five pound four ounce male infant spontaneously with a 350cc. blood loss and a 14 minute third stage. The placenta was delivered by simple expression. On examination there were numerous areas on one-half of the villous surface which revealed hydatidiform degeneration. This was confirmed microscopically. Post partum course was uneventful and X-ray of chest was negative. One year follow-up at regular intervals with frog tests and pelvic examinations was normal.

Case 5: P. K.; 25 years old; Gravida one with last menstrual period February 25, 1956; had uneventful pregnancy until May 23, 1956, when she began to have vaginal bleeding and cramping. On June 10, 1956, bleeding and cramping became more severe, and examination revealed a uterus enlarging normally for gestational period and a cervix dilating slightly. About six hours later patient spontaneously aborted a hydatidiform mole with a 500cc. blood loss. D & C was done and one whole blood transfusion (500cc.) given. Pathology report revealed a Group III, possibly benign mole. Post abortal course was negative in hospital. On July 13, 1956 examination revealed right ovary slightly enlarged and on July 26, 1956, A. Z. test was weakly positive. On August 15, 1956, A. Z. test was positive. No bleeding noted and on August 27, 1956, D & C done by Dr. Lon King and pathological report was negative for trophoblastic tissue. On September 7, 1956, A. Z. test was negative. Except for a prolonged menstrual period the last of September, 1956, and

another one the last of October, 1956, patient has been well to this date.

Comments

It may be readily seen from the review of these cases that no diagnosis was made prior to passage of the characteristic vesicular chorionic tissue. This is true of the majority of cases reported in the literature. Case one in this report was suspected of having a molar pregnancy, but proof was lacking until the products were expelled. This failure of diagnosis is due to the great percentage of threatened abortions and to the varied signs and symptoms this abnormal condition may exhibit which are also seen in the usual run of pregnancies. The uterine size varies considerably and nausea and vomiting can, as has been noted, be just as severe in an otherwise normal pregnancy. Only an acute onset of severe toxic symptoms in early pregnancy would actually force one into making a hydatidiform mole number one on his list of impressions. The use of the biologic test determining the presence and amount of the chorionic gonadotrophic hormone is full of pitfalls in the diagnosis of a molar pregnancy before it is expelled. This is true because of the marked quantitative variations of this hormone⁵ in other pregnancies particularly in twins. The Asheim-Zondek and frog test find their greatest usefulness in the follow-up of molar abortions and choriocarcinoma.

After the abortion of a molar pregnancy, D & C should be done making sure the pathologist is given the aborted products plus the material from the D & C in a separate container. From these materials some prognostication may be made as in case three of this report. Because of the serious hemorrhage which may accompany these abnormal pregnancies, whole blood should be typed and cross-matched for transfusion as indicated. One should also keep in mind the marked possibility of infection and be ready to use antibiotics and chemotherapeutic agents as needed.

If a molar pregnancy is diagnosed before abortion has occurred, D & C should be done before the 12th week of gestation, keeping in mind how easy it is to perforate the uterus. After the 12th week of pregnancy, abdominal hysterotomy is often the best management. Many authors feel that a parous patient over 35 years of age and beyond the 12th week of gestation should have a hysterectomy. The lutein cysts in the case of a molar pregnancy should be left alone, since these cysts will regress and the ovaries return to normal when all of the molar chorionic tissue has been removed. Following the immediate management of the molar pregnancy, adequate follow-up is mandatory. The physician must rule out choriocarcinoma and chorioadenoma des-

truens. It is in the follow-up that the biologic tests are of great importance and help. A frog test may be used and should be done weekly until two consecutive negative tests are obtained. Then the test should be repeated once per month for six months and then every two months for one year. Of course, the possibility of a normal pregnancy occurring during this follow-up period must be kept in mind. The first negative assay may be in four days or may be in four months. If the biologic test remains positive over three weeks, a D & C should be done, or if it becomes positive after being negative, then a D & C should be done immediately. Vaginal bleeding should not be waited for as an indication for D & C. The biologic test, as previously stated, should be the indication for diagnostic surgery as in case three where vaginal bleeding had not occurred.

Choriocarcinoma and chorioadenoma destruens must be constantly thought of in the follow-up of these molar pregnancies. If either choriocarcinoma or chorioadenoma destruens is found, then total abdominal hysterectomy and bilateral salpingo-oophorectomy should be done in the presence of metastases⁶. Removal of any metastasis, if surgically feasible, should be done. Radiation therapy to metastatic lesions⁶ and nitrogen mustard therapy⁷ along with radiation may be used. Large virilizing doses of androgens⁸ have been used with some success in conjunction with surgery. Nitrogen mustard was used in the case reported in this paper along with testosterone. However, this patient must have had lung metastases at least one month before the abortion occurred and no therapy would have been successful.

Chest x-rays of all molar pregnancies should be taken as a base line and then follow-up x-rays as indicated may help in locating early metastatic lung lesions.

Summary

1. Five cases of hydatidiform mole have been presented.
2. One of the five cases died of generalized choriocarcinoma.
3. Diagnosis, therapy, and follow-up have been discussed in both hydatidiform mole and choriocarcinoma.

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THE PERINEAL APPROACH TO THE PROSTATE

The indications and advantages of the more modern method of perineal prostatectomy—both radical and subtotal—are discussed in detail, and the technics described.

W. E. KITTREDGE, M.D., New Orleans, Louisiana

THE PERINEAL APPROACH to the prostate has now been known to urologists for more than fifty years. The original technic was devised by the late Hugh Young¹ in 1904. However its general acceptance at first was slow, largely because of a rather disturbingly high incidence of permanent postoperative urinary incontinence even in the hands of those thoroughly familiar with the technic. In more than 550 collected cases of operations performed by a number of surgeons, this incidence averaged 12.2 per cent. However in more recent years, certain modifications of the original technic, particularly by Belt^{2,3} and others, have contributed greatly to popularization of this method of prostatectomy. By providing a more sound anatomic approach to the prostate with accurate hemostasis and restoration of the continuity of the bladder neck and urethra by suture under direct vision, these improvements have minimized the danger of postoperative urinary incontinence, shortened the convalescent period and reduced the postoperative morbidity. Perineal prostatectomy is now generally accepted as one of the basic surgical technics with which every urologist should be familiar.

Indications

The most important indication for perineal prostatectomy is early carcinoma of the prostate. Prostatic cancer is one of the three commonest malignant lesions encountered in men, the incidence being variously reported as 15 to 30 per cent of men in the older age groups. It causes approximately 12 per cent of all deaths annually from malignant lesions in males. Unfortunately the number of cases of cancer of the prostate that are discovered while amenable to radical surgical cure is still only about five in every 100 despite the fact that about 85 per cent of all cases originate in the posterior capsular

area of the prostate and can therefore be easily recognized by rectal palpation. However, increasing consciousness of the disease and of the possibility of its cure by radical extirpation has led to encouraging results in recent years. For example, Jewett⁴ reported that 19 per cent of the patients seen at the Brady Institute in recent years have tumors that are amenable to radical excision because of the increasing alertness of referring physicians. According to Van Buskirk and Kimbrough,⁵ since 1940 more than 54 per cent of army personnel with carcinoma of the prostate seen at the Walter Reed Hospital had lesions that were amenable to radical perineal prostatectomy. It is indeed regrettable that in spite of the prevalence of this disease it still does not receive the emphasis in cancer publicity that it deserves, and it can only be hoped that in the future early recognition of the disease will become more commonplace.

If radical prostatectomy is contemplated for early carcinoma, the perineal approach offers the only certain method by which a diagnosis of carcinoma can be established by biopsy before the prostate is actually removed. In some instances even then it is difficult for a competent pathologist to be certain of the diagnosis from frozen section alone. It is our practice to defer prostatectomy until permanent sections can be studied whenever there is any doubt about the diagnosis from frozen section alone. Simple exposure of the prostatic capsule and excision of a suspicious nodule for careful pathologic study is almost without risk. If the biopsy report proves to be negative, the patient may be discharged from the hospital with the expectation that there will be no postoperative complications. Other far less certain methods of attempting to obtain representative tissue for microscopic study from suspicious nodular areas in the posterior capsule include transurethral prostatic resection, perineal needle aspiration, Papanicolaou smears of prostatic secretion, and more recently transrectal biopsy of the prostate. However, Grabstald and Elliott,⁶ in discussing their experience

Read before the meeting of the Medical Association of Georgia, May 14, 1956 in Atlanta, Georgia.

PERINEAL APPROACH / Kittredge

with transrectal biopsy, considered open perineal biopsy the procedure of choice and reserved transrectal biopsy for those not trained in perineal surgery in order to avoid an unnecessary radical retropubic prostatectomy in cases in which the biopsy report proves to be negative. In contemplated radical retropubic prostatectomy the urethra must be first transected for the posterior capsule to be properly accessible for biopsy. This commits the operator either to radical prostatectomy in any case or to subsequent restoration of the continuity of the urethra if the biopsy report proves to be negative as is the case in 30 to 50 per cent of such suspicious nodules. It is to be assumed, of course, that in all suspected cases of early prostatic carcinoma in which radical excision is contemplated previous roentgenographic studies show no evidence of bony metastasis and the serum acid phosphatase is normal.

More recently, McDonald and associates⁷ employed the perineal approach for open biopsy followed several days later in positive cases by radical retropubic prostatectomy. This offers the advantages of accurate biopsy along with preliminary dissection of the posterior aspect of the prostate and vesicles prior to the actual prostatectomy and subsequent dependent postoperative drainage through the perineal wound.

Radical perineal prostatectomy is also considered by some to be indicated in patients with small, unsuspected, localized, but wildly anaplastic areas of carcinoma embedded in otherwise benign adenomatous tissue following any type of subtotal prostatectomy. This is in contrast to the frequently encountered low grade focal areas of carcinoma seen in benign glands, which in most instances, have been completely removed by the original subtotal procedure.

Various benign lesions also lend themselves well to perineal prostatectomy. In patients with large benign prostatic hypertrophy who are considered poor surgical risks the perineal approach, because of its low morbidity, is preferred by some if transurethral resection is not feasible. Also, extreme obesity, previous suprapubic surgical procedures, or the presence of large inguinal hernias in patients with large benign hypertrophy sometimes makes either retropubic or suprapubic prostatectomy undesirable. The perineal approach may also be considered in some instances of deep seated, chronic prostatitis with or without calculi in which the disease involves the capsule and is therefore not amenable to complete cure by any type of subtotal prostatectomy. In such cases this approach offers an ideal means for complete removal of the entire prostate and its capsule including all infected and calculous areas.

Familiarity with perineal surgery also makes it possible to obtain successful closure of congenital or acquired recto-urethral fistulas in a high percentage of cases.

Contraindications

Radical prostatectomy is generally considered to be contraindicated in men over 70 years of age with prostatic cancer, however early the lesion may appear to be, since many of these men may be expected to live out their normal life expectancy in comfort with the aid of hormonal and radiational control of the disease. Early attempts to cure certain relatively advanced localized carcinomatous lesions by first attempting to render them operable after short courses of hormonal therapy followed by radical perineal prostatectomy have not proved generally successful.

Technic

The technic of perineal prostatectomy employed by us is substantially the one devised by Belt.^{2,3} A spinal anesthetic is used whenever feasible. The patient is placed in the extreme lithotomy position so that the perineum is parallel to the floor. A rubber dam or a towel is secured over the anal area and the patient is draped in the usual manner. A curved incision is made from one ischial spine to the other, 1.5 cm. above the mucocutaneous anal border. This incision is carried through the median raphe in the midline and the external anal sphincter is exposed. The posterior lip of the wound is depressed with a finger, and the anal sphincter is gently lifted off the rectum with the handle of the knife after which it can be retracted out of the field of vision by two lateral retractors. A posterior retractor is then inserted to depress the rectum. A sound is passed into the bladder and then by deflection of its handle the prostate is pushed forward toward the operator. The median fibers of the levator ani muscles are separated by blunt dissection to expose the fascia covering the posterior aspect of the prostate. If subtotal prostatectomy is planned, no further perineal dissection is necessary. An inverted U shaped incision is then made in the prostatic capsule, the sound is removed, and the distal prostatic urethra is cut across with scissors near the apex of the prostate. A prostatic tractor is then introduced through the lumen of the prostatic urethra into the bladder, and the prostate is pulled forward into the wound for easy accessibility. The adenoma is enucleated with the finger in the same manner as in any other type of open prostatectomy. The bladder neck is caught with Allis clamps in each quadrant of its circumference and pulled down into the field of vision. Four hemostatic catgut sutures are taken around its circumference, which in addition to hemostasis, somewhat reduce the calibre

of the opening of the bladder neck. The bladder neck is then accurately sutured to the membranous urethra over an indwelling Foley catheter by catgut sutures in each of the four quadrants. The prostatic capsule is closed with interrupted sutures, the levator ani muscle borders are reapproximated and a Penrose drain is inserted along the rectal plane. The skin is sutured with interrupted nonabsorbable sutures.

In the radical procedure, after the prostate itself has been completely exposed, Denonvillier's fascia is incised vertically, the prostate is more completely dissected laterally, and the vessels entering the prostate at each inferolateral angle are freed and clamped. This vascular pedicle is then secured by a single transfixion catgut suture on each side. The seminal vesicles are exposed and dissected free together with a portion of the vas deferens on each side. The vessel entering the tip of each seminal vesicle is separately clamped and ligated. The urethra is cut across at the apex of the prostate, and the gland is pulled down and carefully dissected free from the venous plexus lying anteriorly. It is cut away from the bladder neck with scissors after which the same steps in hemostasis and anastomosis of the bladder neck to the urethra are carried out. The superficial fascia is restored, covering the anastomosis of the bladder neck to the urethra, the levator ani muscles are reapproximated and the wound is closed as described in the preceding paragraph.

In the repair of recto-urethral fistulas the same approach is employed after previous diversion of both urine and feces in most instances by suprapubic cystostomy and colostomy. The fistulous tract is exposed, dissected out and removed, the urethra is closed with atraumatic catgut sutures, the lower end of the rectum is mobilized and pulled down in order to excise the defective area if possible, and the rectal border is resutured to the anal margin. All tissue possible is pulled together between the urethra and rectum, and the wound is closed in the usual manner with drainage.

Complications

Postoperative bleeding is minimal after perineal prostatectomy because of the excellent exposure, which provides direct visualization of the bleeding points and enables use of hemostatic sutures around the circumference of the bladder neck. Postoperative urinary incontinence following this technic is rare. It is generally agreed that the high incidence of permanent urinary incontinence following the older methods was due both to actual exposure of the external urethral sphincter to physical damage during the operation and to disturbance of its nerve supply during exposure of the prostate. However, in

the method herein described, the prostate is approached along the rectal plane throughout and at no time is the external sphincter exposed or is any dissection carried out in an area likely to damage its nerve supply.

Rectocutaneous or recto-urethral fistulas occasionally develop after any type of perineal prostatectomy. Most rectal injuries occur during the initial steps of the procedure. A small opening made in the rectum near the rectocutaneous junction may be immediately closed with two layers of atraumatic catgut sutures and the operative procedure continued. In these patients feces may or may not drain through the wound for a brief period postoperatively but the postoperative morbidity and duration of hospitalization are not materially increased, and healing eventually occurs in all of them. Recto-urethral fistulas do not occur in these cases since the temporary surgical defects in the rectum and urethra are not in apposition to each other. However, those defects higher in the rectum at the level of the prostate itself create the risk of permanent urethro-rectal fistulas. In such instances if the rectal injury is recognized before the prostatic capsule has been opened, it is safer to discontinue the procedure, suture the defect in the rectum, and close the wound with drainage. A recto-urethral fistula cannot occur if the urethra has not been opened.

Results

Reported long term survivals without recurrence following radical perineal prostatectomy for early carcinoma of the prostate are steadily accumulating in the literature in sufficient numbers to be impressive. At present at least half of carefully selected patients with early prostatic carcinoma treated by radical perineal prostatectomy have survived from five to ten years without evidence of recurrence.^{7,8-10}

More recently, Jewett⁴ reported ten year survival without recurrence in 49 per cent of carefully chosen patients treated by radical perineal prostatectomy. This compares favorably with the 53 per cent expected survival rate of men of the same age group dying of all other causes. Smith¹¹ reported that 31 of 81 patients treated in this way survived ten years without evidence of recurrence, those dying of other causes during the interim having been excluded. The incidence of 50 per cent five year survival without evidence of recurrence following perineal prostatectomy is about the same as the reported three year survival rate for patients with inoperable carcinoma of the prostate subjected to all forms of hormonal therapy. In Nesbit and Baum's¹² review of 1818 patients with incurable carcinoma treated by a combination of all forms of hormonal therapy, 54.2 per cent of the 947 patients who were followed for three years were alive at the end of that time.

PERINEAL APPROACH / Kittredge

Of the 587 patients followed for five years, 26.9 per cent survived.

During the ten year period ending Dec. 31, 1955, the perineal approach was used on 282 patients at Charity Hospital in New Orleans and at Ochsner Foundation Hospital. In 267 patients either radical or subtotal prostatectomy was performed and in 13 the perineal approach was employed for repair of urethrorectal fistulas. In almost all perineal procedures performed at Ochsner Foundation Hospital during this period, the indication was suspected early carcinoma. The operations at Charity Hospital were performed on all three urologic services and a considerable proportion was performed by the residents under staff supervision.

There were 26 radical perineal prostatectomies, 19 for carcinoma and seven for intractable prostatic infection with or without calculi. The 243 subtotal prostatectomies were done for benign prostatic hyperplasia. Thirteen patients had repair of urethrorectal fistulas, of whom eight were children with congenital or acquired fistulas and five were adults with postoperative fistulas. Ten patients had only perineal biopsy of suspicious prostatic nodules, which ultimately proved to be benign; this represented 31 per cent of all nodules in which biopsy was done.

The case fatality rate for the entire series was 1.7 per cent. Four patients died following subtotal prostatectomy and one following radical prostatectomy. The causes of death were postoperative shock in one, lower nephron nephrosis in one, coronary thrombosis in two, and sepsis in one.

Permanent urinary incontinence occurred in eight patients (three per cent). Mild stress incontinence occurred in nine (3.2 per cent). There were seven postoperative urethrorectal fistulas (2.6 per cent) of which four required perineal repair. There were 11 rectoperineal fistulas (four per cent), of which only two required temporary colostomy for closure. Healing occurred in all patients before leaving the hospital. In four patients a postoperative urethral stricture developed at the site of anastomosis of the bladder neck and urethra, and osteitis pubis developed in one patient.

Of the 19 patients with proved carcinoma treated by radical prostatectomy, 15 are living from eight months to seven years without disease, with an average of 40 months. Two patients died of carcinoma and one of a cardiovascular accident. One

patient is living with demonstrable carcinoma two years postoperatively.

Conclusion

Perineal surgery for both malignant and benign disease of the prostate as well as for repair of rectourethral fistulas now occupies an extremely important place in urology. Improvements in the technic in recent years have greatly diminished the incidence of postoperative complications which heretofore had led to only limited acceptance of this procedure. The impressive incidence of five to ten year survivals following radical perineal prostatectomy for early carcinoma of the prostate in recent years emphasizes the necessity for every urologist to be prepared to offer this procedure to the patient whose prostatic cancer is discovered early enough to be curable. It is hoped that the number of cases recognized in an early stage when amenable to radical surgical cure will steadily increase as a result of both increased awareness of the importance of routine annual rectal examination of the prostate of all men over 50 years of age by practicing physicians in general as well as of increase in cancer publicity on this subject.

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Medical Association of Georgia 1958 Annual Session

April 27-30, 1957

Macon, Georgia

CONTROL OF POSTOPERATIVE PAIN

An objective report of clinical experience with one of the new oral analgesics in the control of pain after surgery.

J. E. SKANDALAKIS, M.D., and W. P. NICOLSON, JR., M.D., Atlanta, Georgia

POSTOPERATIVE FREEDOM FROM PAIN contributes considerably to the success of operative procedures. The absence of pain during the post-surgical period is reflected in a sense of well-being which favorably affects a patient's convalescence. When an individual is in pain, an interplay of psychogenic influences may delay his physical progress.

Ensuring effective postoperative analgesia has therefore always been a prime consideration. The authors have not been satisfied, however, with providing only varying degrees of relief from pain. The main objective has been to create and maintain whenever possible a pain-free state during the entire recuperative period. In order to achieve this, the administration of potent parenteral analgesics is usually required on the day of surgery itself and often has to be continued for several days thereafter. Past experience with commonly used milder oral analgesics has shown that they frequently do not provide the degree and quality of pain relief desirable.

Although parenterally administered narcotics are necessary, there are distinct disadvantages to their use, for example, depression of respiration and possibility of addiction. We have therefore persisted in a search for a more satisfactory oral analgesic and have evaluated new preparations as they have become available.

Recently, a new oral analgesic preparation embodying a striking development on codeine chemistry was introduced. This compound, Percodan* is unlike most currently used oral analgesics in not containing codeine derivative, dihydrohydroxycodone. This substance differs fundamentally from codeine by possessing specific analgesic properties and being four to five times as active as codeine¹⁻⁵ yet producing fewer side effects. It is said to be the first codeine derivative with a selective pain relieving effect which

has been made available to the medical profession⁶.

Pharmacology

The analgesic effects of dihydrohydroxycodone is based upon its action on higher centers. Vehres⁷ observed that small doses have a soothing influence on the cerebrum. In studying its effect on intestinal muscle function he observed no constipation. Mayer⁸ noted that circulatory changes following the administration of dihydrohydroxycodone were insignificant.

Recentyl Blumberg and Carson⁹ studied the analgesic activity of orally administered salt of dihydrohydroxycodone (the hydrochloride and terephthalate) as contained in Percodan with respect to both rapidity of onset of action and duration of effect. In comparing in animals the activity of these salts with codeine phosphate (the ratio of amounts of each being the same as the ratio of these used in clinical medicine, viz., five mg. salts of dihydrohydroxycodone and 30 mg. codeine phosphate), it was found that with the salts, as obtained in Percodan, the onset of analgesia was almost twice as fast as that of codeine and the duration of analgesia was approximately twice that of codeine.

It appeared that a drug with such properties might lend itself to the accomplishment of the adequate analgesia desired and might offer other practical advantages. This study is presented because the results of the initial clinical trials are sufficiently encouraging to warrant the continuation of the use of Percodan and to suggest similar studies by other surgeons interested in this phase of postoperative care.

Material and Methods

The study was planned to determine not only to what extent Percodan could reduce the need for parenteral analgesics but also whether Percodan would afford substantially better relief of pain than the codeine, one-half gr., plus APC combination which was used routinely. The necessary data on this latter

*Percodan is manufactured by the Endo Laboratories Inc., Richmond Hill, N. Y.

POSTOPERATIVE PAIN / Skandalakis

drug were readily available in the charts of patients previously operated upon. These data are utilized in this report.

For the investigation of Percodan a test group was set up and although a study of the analgesic effectiveness of orally administered drugs was the main object, another group was established comprising patients who received only parenteral narcotics so that results could be evaluated in truer perspective.

Proper comparison of drugs depends in the first instance upon their administration in identical fashion. Experience has taught that when patients and nurses, as well as doctors, know that a new drug is undergoing clinical evaluation their judgment suffers, and their findings may be influenced by subjective factors. Therefore, nursing and house staff personnel were not advised that clinical trials were being conducted, but rather it was arranged to have Percodan made available not as a test drug, but as a stock item through the regular channels of the hospital pharmacy. The same dosage demand schedule was used for Percodan as for APC/codeine; one tablet of this combination as required for pain is customarily begun the first day after surgery. Percodan was, therefore, also administered when required in single tablet dosage.

This study includes a total of 174 patients, all

CHOLECYSTECTOMY
CHOLECYSTOSTOMY
HEMORRHOIDECTOMY
HYSTERECTOMY
SALPINGO-OOPHORECTOMY
DILATATION AND CURETTAGE WITH
CERVICAL BIOPSY
VULVECTOMY
CORRECTION OF UTERINE RETROVERSION
WITH APPENDECTOMY
INGUINAL HERNIA (UNILATERAL)
INGUINAL HERNIA (BILATERAL)
INCISION AND DRAINAGE
MASTECTOMY (RADICAL)
INCISION AND DRAINAGE
MASTECTOMY (PARTIAL AND SIMPLE)
EXCISION OF SKIN AND AUXILIARY LESIONS
EXCISION OF PILONIDAL CYST
COLON RESECTION

Table I: Operative procedures.

adults, ranging in age from 24 to 76 years. There were 118 females and 56 males. The operations performed are listed in Table I.

Percodan was used in combination with parenterally administered narcotics and alone in a group of 64 patients. Parenteral narcotics alone were administered to a similar group of 64 patients. The number of patients undergoing each procedure was identical for both groups. The remaining groups were those who in addition to parenteral narcotics had previously received the codeine/APC combination.

For purposes of simplification in this report, the separate groups of patients are termed the Percodan, codeine, and parenteral groups.

As a rule only parenteral narcotics were used on the day of operation. However, there were some categories of surgery where oral analgesics were employed even on the day of operation because it was felt the use of parenteral analgesics could be completely avoided or the quantity and frequency of their administration reduced. The parenteral drugs used were Pantopon® and Demerol®, in single doses of 10 mg. and 100 mg. respectively.

The comparison of the findings is described separately for each type of surgical procedure performed:

Cholecystectomy: In the codeine and parenteral groups, it was necessary to give injections through the second postoperative day, while the patients receiving Percodan required injections on the first postoperative day only.

Cholecystostomy: The Percodan group required only a small amount of parenteral analgesics the first postoperative day; but the parenteral group, through the second postoperative day as well. There was no codeine group for this operation.

Hemorrhoidectomy: Patients in the parenteral and codeine groups required injections of analgesics the second postoperative day. In none of the six patients who received Percodan was this necessary.

Hysterectomy: Patients in the parenteral group required analgesics for three days; the Percodan group required parenteral analgesics for only two days. This operation does not include a codeine group.

Salpingo-oophorectomy: The Percodan group required parenteral narcotics on the day of surgery and the next day, but on the first postoperative day the amount of injectable narcotics for these patients was reduced by 50 per cent. In the parenteral and codeine group, however, there was no such reduction. Further, the patients in the codeine group continued to require injections through the second day.

Dilation and Curettage with Cervical Biopsy: Percodan along with injectable narcotics was started on the day of surgery; these patients did not require any injectable narcotics after the day of operation. The parenteral group required injections the day following operation as well. In the third group, the codeine combination was also started the day of operation and patients required injections not only that day but the next as well.

Vulvectomy: The patients in both the parenteral and Percodan groups required parenteral analgesics on the day of operation and the next day. However, by administering Percodan on the day after operation, the need for injectable analgesics was reduced by half as compared with the needs of the parenteral

group. There was no codeine patient in this operative procedure.

Correction of Uterine Retroversion with Appendectomy: Administration of Percodan was begun the day of surgery. The amount of injectable narcotics on that day and the next was only half that of the parenteral group. This procedure is not included in the codeine group.

Inguinal Hernia (Unilateral): Both the Percodan and parenteral groups required injectables the day of surgery and the next. The injectable amount was cut by half in the Percodan group as compared to the parenteral group. The requirements of the codeine group were the same as of the parenteral group even though codeine was given concomitantly on the day of operation and the first postoperative day.

Inguinal Hernia (Bilateral): Patients in the Percodan group required parenteral analgesics on the operation day, but obtained adequate pain relief the day following from Percodan tablets alone. In the parenteral group, parenteral narcotics were required on the day of surgery and on the following day as well. There was no codeine group for comparison.

Incision and Drainage: The Percodan group did not require parenteral analgesics following this procedure. The parenteral group required analgesics the day of operation. There is no like group for codeine.

Mastectomy (Radical): In all three groups, analgesia by injection was required on the day of surgery and for each of the next two days. In the case of the Percodan group, it was possible to reduce the amount of injectable by half, while in the parenteral and codeine groups there was no reduction in parenteral requirements.

Mastectomy (Partial and Simple): The addition of Percodan to the parenteral schedule on the day of surgery permitted reduction in the frequency and total amount of parenteral administrations. In the parenteral and codeine groups such a reduction was not possible.

Excision of Skin and Axillary Lesions: The use of Percodan on the day of operation obviated the need for parenteral analgesics. Injectables were required on the operation day by both the parenteral and codeine groups.

Excision of Pilonidal Cyst: In the Percodan group, parenteral narcotics were required on the day of operation only; the parenteral group required injectables on the next two days as well. This surgical category was not included in the codeine group.

Colon Resection: The patients in all three groups required parenteral analgesics on the day of operation and two days thereafter. The four patients in the codeine group obtained adequate analgesia from this oral combination from the second day of surgery onward.

Table II presents the parenteral dosage required on the first postoperative day by the patients in each of the three groups for procedures which are common to all three of them. These data reveal an appreciable reduction in the amount of parenteral analgesics administered to the Percodan group as compared with the codeine and parenteral groups.

	A. PERCODAN GROUP		B. CODEINE GROUP		C. PARENTERAL GROUP	
	Pan- topon mg.	Deme- rol mg.	Pan- topon mg.	Deme- rol mg.	Pan- topon mg.	Deme- rol mg.
Cholecystectomy . . .	—	200	—	200	—	250
Hemorrhoidectomy . .	—	200	10	200	10	300
Dilatation and Curettage with Cervical Biopsy . .	—	—	—	100	—	100
Salpingo- Oophorectomy . . .	—	150	—	200	—	300
Inguinal Hernia (Unilateral)	—	100	—	200	—	200
Radical Mastectomy .	10	—	20	200	20	200
Partial Mastectomy .	—	—	—	200	—	—
Simple Mastectomy .	—	200	—	200	—	300
Skin Lesions	—	—	—	—	—	—

Table II: Comparison of parenteral requirements on the first postoperative day in: (A) Group given Percodan, (B) Group given codeine plus APC, (C) Group given parenteral narcotics only.

Table III presents the parenteral dosage required by these same patients on the second postoperative day. The Percodan group required no parenteral analgesics except in one patient who underwent radical mastectomy. The parenteral group required analgesics for cholecystectomy and radical mastectomy. The codeine group, however, required parenteral narcotics except in minor procedures such as dilatation and curettage with cervical biopsy.

No serious untoward reactions with any of the

	A. PERCODAN GROUP		B. CODEINE GROUP		C. PARENTERAL GROUP	
	Pan- topon mg.	Deme- rol mg.	Pan- topon mg.	Deme- rol mg.	Pan- topon mg.	Deme- rol mg.
Cholecystectomy . . .	—	—	—	200	—	200
Hemorrhoidectomy . .	—	—	—	200	—	—
Dilatation and Curettage with Cervical Biopsy . .	—	—	—	—	—	—
Salpingo- Oophorectomy . . .	—	—	—	150	—	—
Inguinal Hernia (Unilateral)	—	—	—	—	—	—
Radical Mastectomy .	10	—	—	200	—	200
Partial Mastectomy .	—	—	—	—	—	—
Simple Mastectomy .	—	—	—	100	—	—

Table III: Comparison of parenteral requirements on second postoperative day in: (A) Group given Percodan, (B) Group given codeine plus APC, (C) Group given parenteral narcotics only.

analgesic agents were encountered. However, the usual mild side effects such as nausea and constipation occurred in all three groups. Drug-induced constipation in the Percodan group appeared to be considerably less than in the other two.

Discussion and Summary

An important detail in the management of the postoperative patient is the establishment and maintenance of a satisfactory pain-free state since convalescence is favorably influenced by the sense of well-

POSTOPERATIVE PAIN / Skandalakis

being engendered by freedom from pain. This can best be accomplished by the parenteral administration of potent analgesics such as Pantopon and Demerol. These drugs, however, cannot be too freely used because of their depressant and habit-forming properties.

On the day of surgery itself, when pain is most severe, these narcotics cannot be replaced. In common with most other surgeons, however, the authors have tried to provide effective analgesia for the following postoperative days by the oral administration of codeine plus APC; however, in many cases the administration of parenteral analgesics had to be continued for periods up to 72 hours even with the addition of this oral combination.

The new analgesic Percodan in a group of 64 operated patients has now been evaluated. A similar group was given parenteral analgesics alone. For purposes of comparison, the codeine, one half-grain, plus APC requirements of patients who had undergone essentially the same surgical procedures were taken from the records of such previously operated patients.

Review of the data reveals that the use of Percodan permitted an appreciable reduction in parenteral analgesic requirements.

Conclusions

Based on this study comparing the postoperative use of parenteral analgesics, codeine with APC plus parenteral analgesics, and parenterally administered analgesics alone, the following conclusion is made:

1. Percodan tablets are an effective oral analgesic

whose action is not accompanied by serious or significant side-effects.

Percodan tablets reduce the need for any frequency and amount of postoperative parenteral narcotics.

3. Percodan tablets are more useful than APC plus codeine in controlling postoperative pain.

4. Percodan tablets favorably influence the period of post-surgical convalescence by maintaining a pain-free state and enhancing patients' comfort.

Addendum: Since the preparation of the foregoing report, the authors have employed Percodan post-operatively in over 200 additional patients who had undergone similar surgical procedures. The observations in this extended series coincide with those above and the conclusions drawn therefrom confirm those already stated.

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AMA ASKS INDUSTRY AID IN FLU INOCULATION

IN A WIDELY DISTRIBUTED news release, the American Medical Association recently asked for the cooperation of American industry in preparing for a probable epidemic of Asian influenza.

The release said that industry should not get panicky and rush into a program of mass inoculation for its employees until essential priority groups in the community have been inoculated.

Dr. Harold C. Lueth, chairman of the A.M.A. special committee on influenza, urged industry to contact local medical authorities for advice before organizing any inoculation program of its own.

"American industry must think in terms of corporate

citizenship," he said and then reviewed the vaccine priority program. Dr. Lueth explained why individual physicians have been urged to adhere to local priority systems. For this reason, he said, industry should not embark upon any program of mass Asian flu inoculation for its employees until it has consulted with local advisory committees made up of health and medical representatives.

Local and state medical societies can generally best answer industry's questions on the subject, the news release said, adding: "They ought to be consulted as to the availability of vaccine and the advisability of any mass in-plant inoculation program."

CRAWFORD W. LONG MUSEUM DEDICATION

September 15, 1957, Jefferson, Georgia

"Man has known pain from his earliest days. This is the story of the effort to remove pain from man's life, a story of the development both of the goal and the techniques for reaching it. Man will someday complete his triumph over pain."

These simple words inscribed on the wall of a small brick building in Jefferson, Georgia, pay tribute to one of medical history's most outstanding figures, Crawford Williamson Long, the discoverer of ether anesthesia. The museum dedicated in his honor on September 15, gives Georgia the only one of its kind in the world to be dedicated to a particular medical discovery. This dedication climaxed a dramatic struggle to proclaim Dr. Long as the first man to use ether anesthesia in surgery and gives him priority in the discovery over two Boston claimants, William Morton, who extracted a tooth without pain, and John Warren who amputated a leg with ether as the anesthetic.

The dedication day found the small city of Jefferson decked out in a colorful array of flags and welcome signs. Store windows displayed appropriate exhibits commemorating the early 1800's, and long dresses and bonnets modeled by women and children gave a piquant 19th century aroma to the day's festivities.

At the formal dedication ceremonies held in the town square at 3:00 p.m., national and state political and medical figures saluted the man who gave medicine its first real foothold in the battle against pain. Presiding over the ceremonies was Lester Rumble, Jr., of Atlanta. W. Bruce Schaefer, Toccoa, President of the Medical Association of Georgia was present to receive the keys of the museum on behalf of the Association members.

A fitting spokesman of the day was Irving M. Pallin, M.D., President of the American Society of Anesthesiologists who acclaimed the honor paid his predecessor in the dedication of the museum but whose own description of Dr. Long's lasting fame gives memorable tribute; "What greater monument to man is there than immortality," Dr. Pallin declared. "The seed he planted has grown into a flourishing tree . . . He provided a new means for surgery to travel to undreamed of heights."

Senator Richard B. Russell praised the tangible

efforts to give Georgia's native sons their proper recognition in history and proclaimed the museum as a "landmark in the field of science and medicine." In the absence of Senator Herman Talmadge, Gov. Marvin Griffin gave the concluding address and made the official dedication of the museum. Following the formal cutting of the ribbon, the building was opened to public inspection.

Flanked by two plain white wooden buildings, the nearly 100-year-old museum bares a starkly impressive frontage. Although not the original office of Dr. Long, the building dates back to 1862 when it was built to replace the old wooden frame that housed Dr. Long's medical equipment.

The renovated interior, a suitable "hospital gray," is divided into two sections. Focal point of the first floor is a scaled three dimensional diorama recreating the memorable event of the operation when Dr. Long removed the carbuncle from the neck of James Venable. Seen in the background is a realistic model of the city of Jefferson as it appeared in 1842. Around the room an array of exhibits are displayed containing many of Long's personal belongings as well as scraps of letters and notes which compile the valuable proof of his initial use of



Figure 1: MAG President Bruce Schaefer, Senator Richard Russell, and Gov. Marvin Griffin are shown inspecting Dr. Long's baby crib which was on exhibit at the C. W. Long Museum.

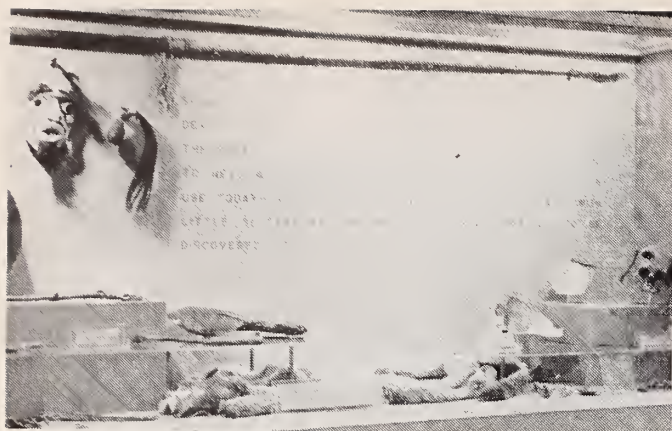


Figure 2: A primitive display is one of the five exhibit booths on the second floor of the museum.



Figure 3: Three dimensional diorama recreates the memorable operation in 1842 when Dr. Long removed the carbuncle from the neck of James Venable.

ether anesthesia. In the collection of mementos is the bill for the removal of the carbuncle, \$2.00 for the operation and 25 cents for the anesthetic.

On the second floor, the history of medicine and the fight against pain are described through impressive combinations of panels, plaques, and exhibit booths. Accompanying this story of the advancement of medicine are water color sketches of many of the

great pioneers of medicine, each portrayed against a background relative to his own particular time, field, or discovery. The exhibits begin with a display of primitive methods of combatting pain and disease and proceed to a display entitled "The Country Doctor" which contains among other things an old medicine chest of tinctures and a kit of surgeon's tools composed of a variety of saws and knives.

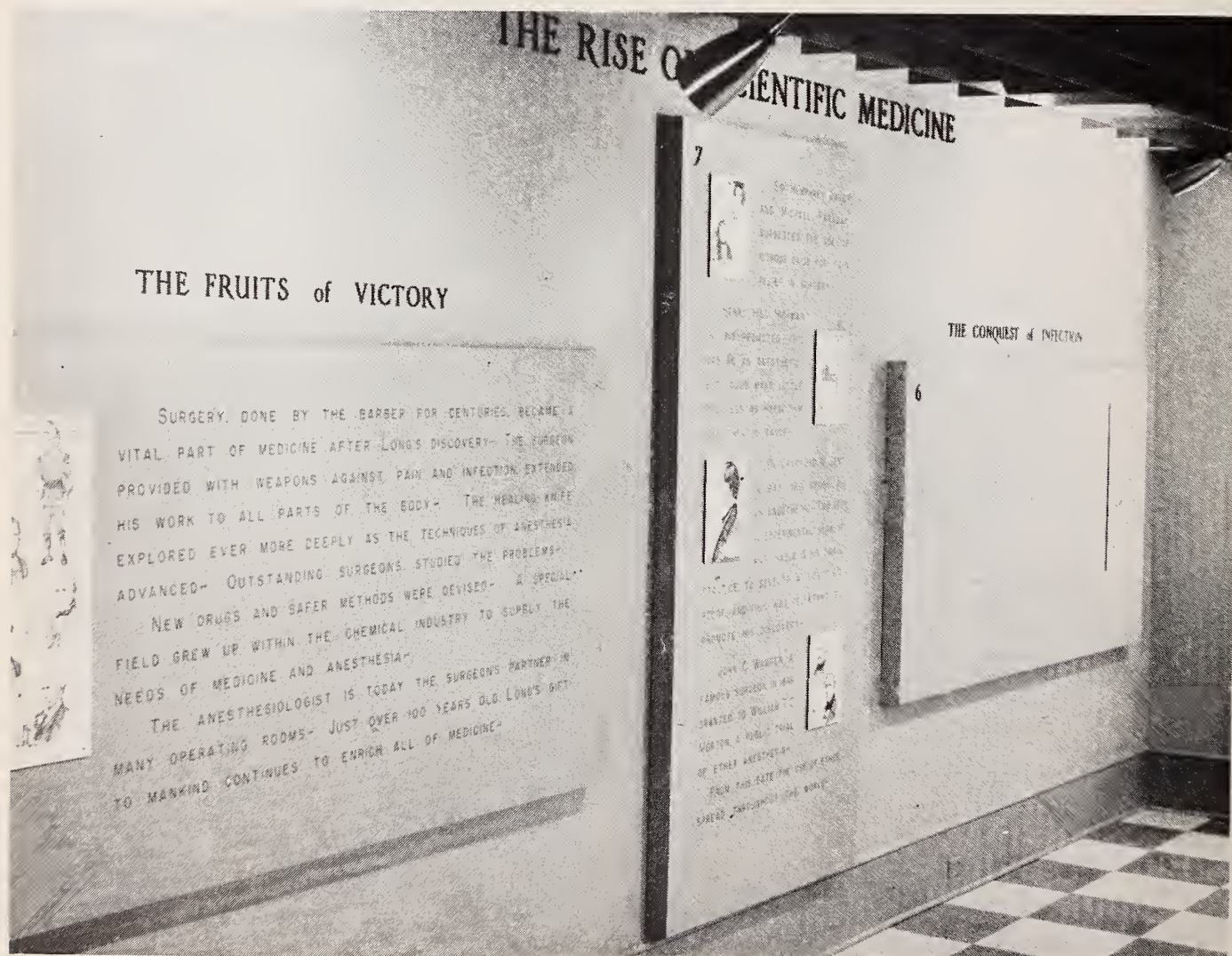


Figure 4: A view of one wall on the second floor of the museum. The account of the fight against pain is described through panels, plaques, and portraits.

1958 Annual Session

April 27-30, 1958—Macon, Georgia



Last Call for Scientific Papers

All titles must be submitted to the respective program chairmen listed below before November 1, 1957.

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RADIOLOGY

W. H. Somers, M.D.
Macon Hospital, Macon

SURGERY

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700 Spring Street, Macon

THORACIC MEDICINE

Samuel E. Paton, M.D.
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CRAWFORD W. LONG / continued

Other booths present anesthetic equipment, old and new, and modern anesthetic drugs and instruments for use in modern specialized medicine.

The dedication of the museum was the second city-wide celebration honoring Dr. Long. Official recognition of his discovery was made in 1940 when a commemorative postage stamp was issued by the Federal Government. In 1910 a country-wide

celebration marked the erection of a monument to Dr. Long which now stands in the city square. The persistence of the people of Jefferson in establishing for Dr. Long the distinction of performing the first painless operation is particularly suitable to the spirit which has prevailed throughout the annals of medical history. Such spirit makes hope for new discovery more than mere hope and gives more than a feeling of optimism to the statement that "Man will someday complete his triumph over pain."

INTRAVENOUS Compatible with common IV fluids. Stable for 24 hours in solution at room temperature. Average IV dose is 500 mg. given at 12 hour intervals. Vials of 100 mg., 250 mg., 500 mg.

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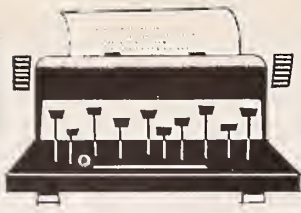
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editorials

TRIBUTE TO A DOCTOR

IN A RECENT NEWSPAPER editorial, the writer was bemoaning the fact that as he walked through public parks he was saddened to see that most of the statues erected are of men whose only virtue was that they were experts in the art of killing their fellows. He remarked that rarely did he find the statue of a man like Pasteur, who probably did more for humanity than did any other man who had ever lived. He went on to place Dr. William G. Morton as the man who did the most to give us the great boon of anesthesia in surgery. To those of us who are residents of Georgia, Morton would not be the proper person on whom to place the credit for the discovery of anesthesia.

The writer of that editorial will undoubtedly be pleased to know that the citizens of Jefferson, Georgia, the members of the Medical Association of Georgia, and the officials of the state of Georgia have erected in the city of Jefferson a memorial to the man who gave the first anesthetic with ether for a surgical procedure, Dr. Crawford Williamson Long.

Five years ago on the spot where this event took place there stood a building. This building was not the original office of Dr. Crawford Williamson Long but a building erected some ten or twenty years following his period of practice in Jefferson. At that time this building could scarcely be distinguished from any other of the structures on the square of this small Georgia city. It had most recently housed used automobile parts, and one had to look carefully through a mass of bright yellow paint in order to identify the metal plaque which had been placed on the side of the building describing in a few words this monumental event. Several tributes have been paid to Dr. Crawford W. Long. There is a monument on the square of Jefferson, Georgia, which pays tribute to his discovery. In the library at the

University of Georgia there are several mementoes to this alumnus of that college. His statue has been placed in the Hall of Fame in Washington, D. C., and his portrait placed in the Academy of Medicine in Atlanta, and also in the International Hall of Fame of the International College of Surgeons in Chicago. To Dr. Frank Kells Boland this did not seem to suffice as a tribute to the man who discovered anesthesia and whose discovery led to the development of anesthesia as it is known today.

Dr. Boland had worked long and hard on gathering information regarding Dr. Long and his discovery. His work was climaxed in a book published by the University of Georgia press which describes all of the circumstances of the first anesthetic and places in its proper perspective the demonstration put on by Morton in Boston some years later. Dr. Boland was assisted in his endeavors by Dr. Jacobs, Dr. Hardman, and Dr. Smith, all of these men being interested in keeping the memory of Dr. Long alive. However, it was Dr. Boland who one day upon viewing the building in its rather run down condition made the statement that it would be very apropos if a memorial of some type could be erected on that site.

Out of this suggestion there arose a drive in Jefferson to collect enough money to purchase the property. Through contributions of nickels, quarters, and dollars, and at times even more, the citizens of Jefferson and Jackson County were able to raise \$2,500 towards the purchase of this building. The Georgia Historical Commission then matched that amount and the property was purchased. Governor Herman Talmadge, at the end of his term of office, contributed \$25,000 towards the renovation of this building. This was accomplished over the period of the next year, and in 1956 Governor Marvin Griffin allocated \$30,000 toward the completion of the interior of the museum.

Space does not permit a description of the contents of the museum, since such a description even in short form occupies a sizable brochure. The pictures included in this issue of the *Journal* will serve to give a birds-eye view of what is in the museum, which is the first of its type in the United States, and possibly in the entire world. This museum is only the nucleus of the final plan to attempt to tell the story of anesthesia right on the spot where the first anesthetic was administered. We trust that those of you who attended the dedication and have viewed the museum are happy with what you saw. We encourage anyone who is in the vicinity of Jefferson, Georgia, to make it a point to visit this memorial site.

Following the dedication of the museum, its maintenance and upkeep will be the joint responsibility

of the Medical Association of Georgia and the citizens of Jefferson, Georgia. Although the museum remains the property of the state of Georgia, the responsibility for its future development will lie with the Medical Association of Georgia through a committee established for that purpose. The maintenance of such a project will not be expensive but will require the allocation of funds in order that it may be maintained properly and can become a site in which every doctor in Georgia can be proud. We hope that Dr. Boland and the others so interested in seeing a satisfactory memorial erected to one of the outstanding men of our state will be pleased with the results of the efforts made by so many citizens of Georgia.

THE CHALLENGE OF ERYTHROBLASTOSIS FETALIS

HEMOLYTIC DISEASE OF THE newborn presents a challenge to all physicians. Thorough comprehension of the available knowledge and prompt and adequate treatment of the affected newborn infant will often permit the doctor to prevent an unnecessary death or to save a human brain from devastating and irreparable damage. This is one situation in medicine where therapy must not be too little nor too late. Not enough publicity has been given to the fact that surviving erythroblastotic infants who receive inadequate treatment suffer severe brain damage. Most published papers simply list the number of infants which lived and the number which died without discussing the neurological status of the survivors.

Ignorance of the facts is widespread and amazing. The author knows a clinical professor of pediatrics in a medical school who thinks that all infants who develop kernicterus die. He also knows a prominent pediatrician who thinks that the infant's blood type is changed permanently from Rh + to Rh — after an exchange transfusion. Another prominent pediatrician is unaware of the extreme variability of the disease and thinks that each succeeding Rh + pregnancy results invariably in a more severely damaged fetus. Still another pediatrician believes that one exchange transfusion is enough, unaware that his better informed colleagues often find it necessary to give several.

The best available treatment according to authorities with the most experience is an exchange transfusion given immediately after birth and repeated as often as indicated by serum bilirubin and hemoglobin levels done every six hours. The serum bilirubin should not be permitted to rise above 20

mg. per cent and the hemoglobin to fall below 13.5 gms. per 100 c.c. It is poor therapy to postpone exchange transfusion for several hours after birth simply because the latter occurs at an inconvenient time. It is also poor therapy to try to base one's decision regarding when to repeat the exchange on physical signs because the hospital laboratory is not able to do micro-bilirubin determinations. It is criminal negligence to wait for abnormal neurological signs, such as opisthotonos, before repeating the exchange transfusion. By the time such signs appear, irreparable brain damage has been done.

Inadequate therapy results in severe anoxia of the brain with cell destruction in the cerebral cortex, basal ganglia, and cerebellum. The child with a severe brain injury may be unfortunate if he survives. He becomes more yellow, more feeble, and more lethargic. Finally marked opisthotonos occurs. If exchange is done at this time, he may survive and will be severely brain-injured. If it is not done, he will die.

Such a brain-injured child is markedly retarded in his neuromuscular development. Holding up his head, reaching for objects, sitting up, pulling up, crawling, and walking are greatly delayed. His muscular coordination is very poor with the result that his motor activities are jerky and clumsy. Learning to walk is exceedingly difficult because of his inability to maintain his equilibrium. He suffers many falls, often striking his head, and may in this way suffer further brain damage. Learning to talk may be delayed to age four or five years, and mental retardation may be so severe that he will never talk. He is apt to be hyperkinetic and may suffer from athetosis. He is restless, sleeps very little, and presents a difficult behavior problem. Because of his cortical damage, he is very prone to have febrile convulsions.

A physician who has neglected to give adequate therapy to a newborn erythroblastotic infant is apt to be cursed many times by feelings of guilt and self-recrimination as he watches such a crippled child develop, unless he is protected by ignorance of what might have been accomplished by good treatment.

For the parents and siblings, such a child creates great emotional, social, and economic problems. Parents suffer from profound disappointment and grief. Some require psychiatric help because of ambivalence towards this problem child with resulting feelings of guilt and depression or over-protectiveness and obsessiveness. Because he is hyperkinetic, restless, and unpredictable, he requires the constant attention of some member of the family lest he seriously injure himself or damage valuable property. He sleeps very little and keeps his parents awake. They become very fatigued and find that they no

longer have time for their previous recreational and cultural pursuits. Well-meaning advisors suggest that they place the child in an institution, but they cannot bring themselves to do this because of their mixed love and guilt feelings and their hope that he will "grow out of" his disabilities. So he is kept at home where he interferes with the social life of his siblings and places a considerable economic burden on his parents. As he grows older, he is unable to support himself and must continue to be a burden on members of his family. Laymen who do not understand his affliction regard him as an idiot or a psychotic.

Thus, a pregnancy in an Rh — woman with an Rh + husband presents a real challenge. The attending physician has a moral obligation to follow the woman's anti-Rh titer, to familiarize himself with the latest available scientific information about the disease, to decide whether or not to deliver the infant at eight months and whether or not to try steroid therapy, to arrange for adequate laboratory facilities and for ample Rh — blood for transfusion, as well as for technical facilities for doing the exchanges. It is his obligation to see that the newborn receives prompt and adequate therapy. This is an emergency of such magnitude that he can hardly do less than cancel all his appointments, if indicated, and remain in constant attendance on the infant for the first twelve to twenty-four hours. In his hands rests the challenge not only to save a human life but, more important, to prevent a fellow human being from spending a lifetime as a mental and neurological cripple.

THE ILEUM IN UROLOGY

SEVENTEEN YEARS AGO Bricker¹ proposed and popularized the use of a segment of ileum as a receptacle-reservoir of urine in cases of pelvic exenteration. Following the removal of all pelvic organs for cancer of the prostate, bladder, or female genital tract as well as the distal bowel, the ileum was found to be a satisfactory site for implantation of the ureters. Three years after his initial report Bricker² concluded that "the use of isolated segments of terminal ileum as a bladder substitute is technically simple; it is attended by few early or late complications; and the patients are satisfied with this method of urinary drainage."

It was soon well established that ileum was a choice bowel segment to receive the diverted urinary stream and convey it to a bag cemented to the skin.

Urologists the world over adopted the technique. This was the answer to the poor results of an older and very popular method of urinary stream diversion—ureterosigmoidostomy. Brilliant investigations^{3,4} of the pathogenesis, and implications of electrolyte imbalance in ureterosigmoidostomy established the need for a more desirable technique of urinary stream diversion. These studies coincided with the experiences and reports of uretero-ileal anastomosis. For those individuals who had been subjected to ureterosigmoidostomy for one reason or another and who numbered themselves among the very high percentages of poor results due to recurrent bouts of pyelonephritis, hyperchloremic acidosis, and eventual renal failure, the ileum was a haven for the return to improved renal function and better health. The world medical literature became replete with reports of the "taking down" of the ureterosigmoidostomy with its dilated ureters and hydronephrotic kidneys. These ureters were transferred to an isolated ileal loop. The patients have made remarkable recoveries.

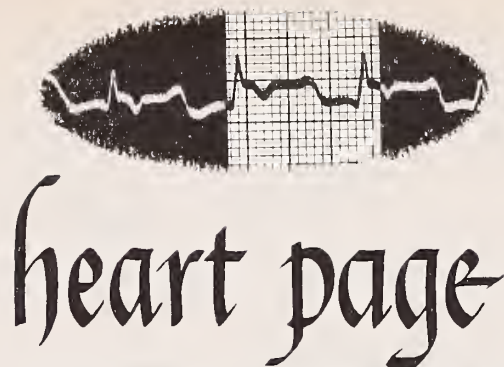
The technique, as Bricker pointed out, is easy and not fraught with great danger. Hence the urologists^{5,6} began to apply the technique to many urological disease entities. The exstrophic bladder, the incontinent bladder of neurogenic origin, and the carcinomatous bladder were prime indications for uretero-ileal anastomosis. But the urologist has extended the use of the ileal segment beyond these initial successes. When placed adjacent to the contracted bladder (ileocystostomy) to increase bladder capacity, relief has been provided the patient with tuberculous or interstitial cystitis which has failed to respond to conventional therapy.

The ileum may be substituted for the irreparably damaged or diseased ureter and thereby salvage an otherwise doomed kidney; i.e. a uretero-ileoneocystostomy. If it is necessary to remove the ureter from any point distal to the ureteropelvic juncture, a segment of ileum can be substituted in such a way that the divided ureter is attached to the ileal loop at the one end and the opposite end of the loop attached to a new bladder site. If sufficient loop is used, reflux of urine up the ileal ureter during micturition is harmless.

Since Verhoogens⁷ first attempted in 1908 uretero-ileostomy, great strides have been made in the development of the surgical technique for urinary stream diversion and the understanding of metabolic changes which occur as the result of such diversion. It would seem that after 50 years the urologist has now at his disposal a physiologically sound surgical procedure for the satisfactory diversion of the urinary stream.

Chest Pain and Dyspnea In General Practice

ROBERT C. MAJOR, M.D., Augusta, Ga.



THE DEFINITION OF "PAIN" as applied to symptoms arising from bronchogenic carcinoma may be narrow or broad. Pain in the narrow sense is definite and lends itself to description as to character and location. This sort of pain arises from metastasis or, more commonly, direct extension of tumor to parietal pleura, rib, intercostal nerve, brachial plexus, pericardium, or spine. It is ominous, usually indicative of incurability. Pain in the broad sense includes vaguer sorts of discomfort, difficult of description and of anatomical explanation. This is a common accompaniment of bronchogenic carcinoma and may mean nothing on one hand or widespread mediastinal invasion on the other. Tightness, pressure, fullness, soreness, rawness, transient, varying with position, with cough, with effort, with infection, these are the symptoms of perhaps early cancer. Then there is the pain of pleural inflammation secondary to bronchial obstruction and distal infection, to cancer necrosis, and to infarction from vascular obstruction by cancer.

The usefulness of pain as an aid in early diagnosis of cancer has been limited, since the severe type is apt to be associated with the obvious and the discomfort type is apt to be ignored or underestimated. It does not seem that much confusion arises in differentiating cancer pain from cardiac pain in contrast, for instance, to non-cancerous problems about the lower esophagus and diaphragmatic hiatus.

Dyspnea, like pain, varies in its significance when associated with bronchogenic carcinoma but is usually discouraging. Severe anemia and massive pleural effusion from metastases are readily apparent causes of dyspnea and are equally foreboding.

Dyspnea from partial tracheal obstruction or from partial or complete major bronchial obstruction is probably the commonest type. Obstruction may arise from tumor in the airway itself, or from distortion of a lumen by pressure of primary tumor or nodes. Understanding of the dyspnea is apt to require in-

formation from endoscopic examination as well as from physical and x-ray examination, the latter including inspiration and expiration films as well as fluoroscopy. Obstruction may be so nearly complete that inflation of the lung is barely maintained. If ingress of air exceeds egress and is sufficient in amount, emphysema develops beyond the obstruction and may result in more dyspnea than total obstruction at the same level with atelectasis beyond. Volume relationship of obstructed to unobstructed lung on the same or opposite side is undoubtedly of importance in this phenomenon. Of more importance, probably, is greater blood flow through obstructed but inflated lung than through atelectatic lung, oxygen uptake being essentially nil in either case.

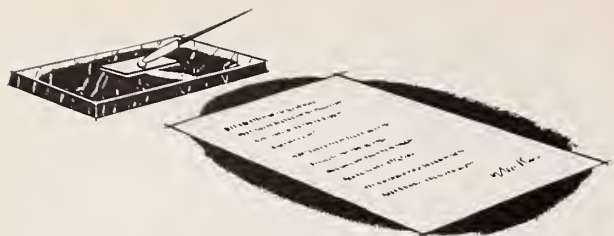
The dyspnea of certain patients with superior vena caval obstruction is a complex of both vascular and airway factors aggravated by fear. Sudden dyspnea suggests phrenic paralysis although pneumothorax is a possibility with either primary or metastatic cancer. Sharp dyspnea with paroxysms of cough, much out of proportion to the resting state, is likewise suggestive of paradoxical motion in a paralyzed diaphragm.

Dyspnea may accompany massive replacement of lung tissue by primary or metastatic cancer but the extent of involvement required is always amazing.

Dyspnea is much more likely than pain to lead to confusion between carcinoma and heart disease. Carcinoma may develop most deceptively in patients with known heart disease, particularly the emphysema—cor pulmonale type. Dyspnea of obstruction and fear may be interwoven with dyspnea of heart failure in various combinations, and the cancer picture may mask myocardial infarction, myocardial failure, or pericardial tamponade.

Pain or dyspnea should not substitute for reasonable proof of either the diagnosis of cancer or the inoperability of cancer.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.



abstracts by georgia authors

Wilkins, Sam A., Jr., M.D., F.A.C.S., and Vogler, William R., M.D., Emory Hospital, Emory University, Ga. "Cancer of the Gingiva," *Surg., Gynec., & Obst.* 105:145-152 (August) 1957.

Over a 19 year period 81 cancers of the gingiva were observed among 512 patients with cancer of the mouth of 8,828 patients with malignant lesions found in 25,246 new admissions. The ages ranged from 39 to 80 years. Fifty-four per cent were females. Seventy-nine lesions were squamous cell carcinoma, one an adenocarcinoma, and one a chondrosarcoma. Sixty-four lesions were located on the lower gingiva and 17 on the upper. Treatment consisted of irradiation, surgery, and a combination of the two. More extensive surgery was used during the latter part of the period studied. All patients were followed.

Thirty-one per cent of patients diagnosed five or more years ago and 40 per cent of those diagnosed two to five years ago were free of cancer. Eighty-eight per cent of recurrences appeared within two years after diagnosis. Fifty-four per cent of the failures were due to local recurrence, 27 per cent to metastasis, 12 per cent to local recurrence and metastasis, and seven per cent to multiple primary cancer.

Although surgery and irradiation are equally effective in treating local disease, surgery is the treatment of choice of certain advanced lesions and regional metastases. Further extension of surgical methods bears little promise. The judicious use of both modalities will salvage a few additional patients. Local recurrence remains the major problem for attack.

Martin, J. D., Jr., M.D., and Stone, H. Harlan, M.D., Emory Hospital, Emory University, Ga. "Perforations of the Gallbladder," *Geriatrics* 12:476-480 (August) 1957.

Though not so common as they once were, perforations of the gallbladder are still frequently seen. This condition is usually found in less than one per cent of all operations upon the biliary system, although its incidence has been recorded as high as 5.2 per cent. If only

those cases of acute gallbladder disease are considered, the frequency is more striking. These figures range from three to 25.6 per cent, with the majority of the larger series being between nine and 16 per cent.

The following is a working classification of perforations: (1) acute—with free communication into the peritoneal cavity; (2) subacute—with pericholecystic abscess, walled-off by adhesions of the liver; and (3) chronic—with free drainage extraperitoneally, either into a hollow viscus or externally.

Since a past history of biliary symptoms can be obtained in the majority of these cases, an elective cholecystectomy should be urged. The 90 per cent incidence of stones is another indication for interval operation prior to an acute episode. Many patients are known to have stones for years, although severe symptoms do not appear until the later years of life. At that time, operation is met with complications; but, nevertheless, it must usually be done. This risk to older people can be avoided by removing these diseased gallbladders with stones when the diagnosis is first made. The morbidity and mortality under those circumstances is negligible. It has been shown that most gallstones will eventually cause a variety of complications.

Stergus, Ingrid, M.D., Battey State Hospital, Rome, Ga.; Nieburgs, Herbert E., M.D., Brooklyn, N. Y.; Stephenson, Evelyn M.; and Harbin, B. Lester, Rome, Ga. "Mass Screening of the Total Female Population of a County for Cervical Carcinoma," *J.A.M.A.* 164:1546-1551 (August) 1957.

Cytological examinations of smears obtained directly from the endocervical canal with the aid of a speculum, or less directly by using a special cancer detection tampon, in 17,761 women studied by 27,894 smears representing practically the entire female population over the age of 19 years in Floyd County, Georgia, revealed cancer cells in the specimens of 117 patients; biopsy material was obtained from 84 of these. Carcinoma in situ was found in 56 women (two of whom were 19 years of age) and invasive carcinoma in 28.

The average age of women with carcinoma in situ was 39; that for carcinoma in situ with early invasion, 41.6; and that for frankly invasive cancer, 47.8. For the total white female population the prevalence rate of cervical carcinoma in situ was 2.8 per 1,000 and for invasive cancer 1.4 per 1,000. To determine the true incidence rate for cervical carcinoma in situ, repeat examinations were carried out over a period of four years on women known not to have had a cervical lesion at the time of the first examination. The date for incidence indicated that, in every 1,000 women, 1.8 new cases of cervical carcinoma in situ developed each year.

Hook, Edward W., Jr.; Wainer, Howard S.; McGee, T. Jack; and Sellers, Thomas F., Jr., 69 Butler St., S.E., Atlanta 3, Ga. "Acquired Arteriovenous Fistula and Endocarditis," *J.A.M.A.* 164:1450-1454 (July) 1957.

Bacterial endarteritis occasionally develops in acquired arteriovenous fistulas which are large and of long standing. Five of the 13 patients with endarteritis complicating acquired arteriovenous fistula described in the American literature have also had bacterial endocarditis of the aortic valve. Although surgical excision and/or antimicrobial therapy have effected a cure in all reported cases of endarteritis alone, no cures have been reported in patients who also had endocarditis.

Two patients with acquired arteriovenous fistula are described in which the problem of endarteritis and endocarditis arose. The first patient had endocarditis in a large fistula between the femoral artery and vein, and endocarditis was considered to be present because of aortic insufficiency and peripheral embolic phenomena. His temperature remained elevated despite antimicrobial therapy but promptly became normal after surgical removal of the fistula. The second patient, with an extensively calcified aneurysm involving the subclavian vessels, was not conclusively proved to have endarteritis. His temperature also showed no change during antimicrobial therapy but returned to normal after excision of the fistula. The first patient died one year after surgery with manifestation of severe aortic insufficiency, and the second made a good recovery. These cases illustrate that in certain instances removal of an arteriovenous fistula may contribute greatly to the control of complicating intravascular infection by antimicrobial drugs.

Rothe, Carl F., Ph.D.; Mattson, Arnold M., Ph.D.; Nueslein, Rose Marie, B.S.; and Hayes, Wayland J., Jr., M.D., Public Health Service, U.S. Department of Health, Savannah, Ga. "Metabolism of the Chlorophenothane (DDT)," *Arch. Indus. Health* 16:82-86 (July) 1957.

Of the intestinally absorbed radioactive DDT administered orally to rats with their thoracic lymph ducts cannulated, 47 to 65 per cent was recovered in the chyle. Furthermore, 14 to 46 per cent of the absorbed DDT-derived materials found in the chyle were dehydrohalogenated into a neutral material (DDE).

Wolcott, M. W., Veterans Administration Hospital, Atlanta, Ga.; Ellison, Robert G., Medical College of Georgia, Augusta, Ga. "Insertion of a Hufnagel Valve for Aortic Insufficiency Complicated by Development of a False Aneurysm," *J. Thoracic Surg.* 34: 111-115 (July) 1957.

Insertion of a Hufnagel valve in a 48-year-old negro man suffering from aortic insufficiency is reported. Insertion of the valve was complicated by difficulty of accurate fit, a number three valve being too large while a number two valve was found to be slightly too small. It was necessary to control the slight leak by use of lightly placed silk sutures. The postoperative course was complicated by some fever. He was considerably improved for seven months and then died of asphyxia due to leakage of a false aneurysm into the superior segment of the left lower lobe. The difficulty of accurate fit is great and may be exaggerated in the other arteriosclerotic aorta which because of its decreased elasticity requires a much more accurately fitting valve. Range of selection might be improved by the addition of a size between the number two and number three valves.

Fish, J. S.; Bartholomew, R. A.; Colvin, E. D.; Grimes, W. H.; Lester, W. M.; and Galloway, W. H., Atlanta, Ga. "Rupture of the Marginal Sinus," *J. Int. Coll. Surgeons* 28: 47-53 (July) 1957.

Rupture of the placental marginal sinus accounts for 39 per cent of third trimester pregnancy hemorrhages. In distribution, character of bleeding, and related clinical observations, bleeding from this source resembles placenta previa most closely. The spontaneous recurrence rate is half that of placenta previa. Final differentiation is based upon vaginal examination.

The major problem originating in sinus rupture is prematurity. Virtually half of all sinus hemorrhages are followed by labor within twenty-four hours, some 22 per cent of all prematurity being due, in the authors' experience, to this accident.

Unless spontaneous labor intervenes, marginal sinus hemorrhage may be managed expectantly with safety, and the child should be delivered through

the pelvis. Since there is no need for differentiation between placenta previa and sinus rupture before definitive treatment is planned, and since diagnosis is more accurate and induction of labor safer with a prepared cervix, the postponement of diagnostic vaginal examination until the end of the course of expectancy is recommended.

Kaplan, William, D.V.M., and Georg, Lucille K., Ph.D., Public Health Service, U.S. Department of Health, Atlanta, Ga. "Isolation of *Microsporum Audouinii* from a Dog," *J. Invest. Dermat.* 28:313-315 (April) 1957.

The authors report a case of ringworm in a 10-week-old boxer puppy caused by *Microsporum audouinii*. The dog involved had recently been purchased by a family with two children under dermatologic care for tinea capitis. The authors discuss the significance of this case from an epidemiologic standpoint.

McGariety, William C., M.D., F.A.C.S., Emory Hospital, Emory University, Ga. "Regional Enteritis of the Duodenum," *Surg., Gynec., & Obst.* 105:203-203 (August) 1957.

Twenty-five cases of regional enteritis involving the duodenum reported in the literature are reviewed and another case is added. The author presents the case of a 46 year old female with known regional enteritis of the terminal ileum who developed duodenal obstruction due to regional enteritis. Relief of the obstruction and a return of normal weight and bowel habits followed a posterior gastrojejunostomy and vagotomy.

Duodenitis may be an isolated part of the entity regional enteritis; it may develop into a generalized form; or it may occur months to years before or after regional enteritis is found in the small bowel or stomach. The possible presence of this disease should be kept in mind during the differential diagnosis of obstructing lesions of the duodenum. A preoperative diagnosis of regional enteritis of the duodenum should always be considered if upper gastrointestinal symptoms develop after a diagnosis of regional enteritis has been made elsewhere or in the presence of any obstructing lesion of the small bowel. The roentgenologic findings and

clinical course are discussed. The surgical treatment of choice in a patient with advanced regional enteritis of the duodenum, if the stomach and major portion of the jejunum are not involved, appears to be a posterior gastrojejunostomy plus vagotomy.

Williams, R. C., Georgia Department of Public Health, Atlanta 3, Ga. "Formal Training for Hospital Administrators at the Undergraduate Level," *J. Am. Hosp. Assn.* 31:51-53 (May 16) 1957.

Approximately 80 per cent of the hospitals in the United States have a capacity of less than 100 beds. There is need for persons prepared in hospital administration to serve these smaller hospitals. This problem has become more pressing as a result of the construction of smaller hospitals both in and outside of the Hill-Burton Act program. To improve the administration of smaller hospitals, the Georgia State College of Business Administration in Atlanta, Georgia, in 1952, developed a course of instruction intended primarily to train persons as administrators of hospitals of less than 100 beds.

The small hospital presents unique problems of administration. There are close personal contacts between workers in the small hospital due to fewer employees and the frequent close interaction of departmental personnel resulting from a smaller physical plan. Relationships are further intensified by the variety of skill needed in a minimum staff in the various service areas of the smaller hospital.

A total of 117 students have enrolled since the course began in the fall of 1952. Of this number, 44 had college degrees. Seven were registered nurses. With few exceptions, all others had a minimum of two years of college work. The modal age of students is 28 years.

Certificates in hospital administration have been awarded to 48 students by the regents of the University System of Georgia upon satisfactory completion of their work at this institution. Twenty-seven weeks of hospital training is required for the granting of a certificate in addition to the three quarters of academic work. An evening schedule of classes permits students who desire employment to hold positions during the day.

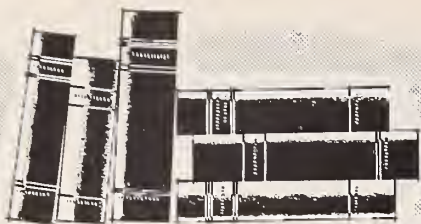
AUDIO-VISUAL AIDS NEEDED

THE AMERICAN COLLEGE of Obstetricians and Gynecologists is undertaking the compilation of a registry of audio-visual aids in education in the fields of obstetrics and gynecology as well as in allied fields pertinent to the specialty such as endocrinology, genital physiology and anatomy, newborn care, drug research and obstetrical or gynecological psychiatry.

Among such aids may be motion pictures, audio-visual lectures, tape recordings, manikins, charts, graphs and similar displays designed for use by specialists, general practitioners, students, nurses or lay groups.

The titles of any aids in the above categories which are in your possession or of which you have knowledge should be forwarded to Dr. John S. Fish, chairman, 272 Boulevard, to be included in the Georgia section of this registry.

In addition to a reference source for all interested parties, this registry will be the source of selections for material for district or national college programs and selections for awards of certificates of merit to be conferred by the college.



physician's bookshelf

BOOKS RECEIVED

Philipp, Elliot P., **FROM STERILITY TO FERTILITY, A Guide to the Causes and Care of Childlessness**, Philosophical Library, New York, 1957, 118 pp., \$4.75.

Page, Robert Collier, M.D., **IT PAYS TO BE HEALTHY**, Prentice-Hall, Inc., Englewood Cliffs, N. J., 1957, 282 pp., \$4.95.

Dill, Leslie V., M.D., **MODERN PRENATAL CARE**, Appleton-Century-Crofts, Inc., New York, 1957, 299 pp.

Gleason, Marion N.; Gosselin, Robert E., M.D.; and Hodge, Harold C., PH.D., **CLINICAL TOXICOLOGY OF COMMERCIAL PRODUCTS**, The Williams and Wilkins Co., Baltimore, 1957, 1160 pp.

Palmer, Harold, M.D., **PSYCHOPATHIC PERSONALITIES**, Philosophical Library, Inc., New York, 1957, 175 pp., \$4.75.

Levy, Carroll Morton, M.D., **PRACTICAL DIAGNOSIS AND TREATMENT OF LIVER DISEASES**, Paul B. Hoeber, Inc., 318 pp., \$8.50.

Lassek, A. M., M.D., **THE HUMAN BRAIN**, Charles C. Thomas, Springfield, Illinois, 1957, 212 pp., \$4.75.

Stern, Neuton S., M.D., and Stern, Thomas N., M.D., **THE BASES OF TREATMENT**, Charles C. Thomas, Springfield, Illinois, 1957, 166 pp., \$4.75.

Keeney, Arthur Hail, M.D., **LENS MATERIALS IN THE PREVENTION OF EYE INJURIES**, Charles C. Thomas, Springfield, Illinois, 63 pp., \$3.50.

REVIEWS

Nesselrod, J. Peerman, M.D., **CLINICAL PROCTOLOGY**, Second Edition, W. B. Saunders Company, Philadelphia, 1957, 296 pp., \$7.00.

This second edition on clinical proctology by Dr. Nesselrod is an indispensable aid to the specialist in this field and to any physician who has occasion to see patients with anorectal disorders.

It is unusual to find among the medical texts a volume which is so easily read and yet one which describes in detail the various manifestations of anorectal disease. The anatomy and physiology of the perineum and pelvis are described as in most anatomy books, but in addition there are several diagrammatic parasagittal sections demonstrating the anatomy as encountered dur-

ing a digital examination in the inverted position. After elaborating on the very logical and sound theory of anal infection as the initiating factor in the common anal diseases, the author describes the pathologic physiology, then diagrammatically presents the proper surgical techniques to eradicate the disease process.

Prolapse of the rectum, anorectal malformations, and neoplastic disease are discussed briefly, but the medical management of irritable bowel syndrome, ulcerative colitis, and diverticulitis were not considered within the scope of this book.

Dr. Nesselrod is a recognized authority on anorectal diseases, and as such, has crystallized the accepted current therapy by integrating his own experiences with those of others in this field.

Edwin Lockridge, Jr., M.D.

Cleckley, Hervey, M.D., **THE CARICATURE OF LOVE**, The Ronald Press Co., New York, 1957, 311 pp., \$6.50.

Dr. Cleckley pursues two themes; the sexual disorder with its influences and a critical examination of some popular psychological and psychiatric theories. He contrasts his clinical experience with these concepts. An argument is developed against the idea that the condition of homosexuality is natural and the equivalent of heterosexual life. It is his contention that theories of sexuality are offered as actual scientific discoveries to support the idea that this condition is natural. He traces the development of methods by which these concepts have been devised, and to support his argument he quotes extensively from novels, plays, and poetry exposing manifestations of pathological sexuality.

While the author does not shed any new light on the condition or offer any method of management, he does stress the need to resist the efforts to make the condition fashionable or to ridicule those opposing the currently popular ideas. He supports his thesis in a well documented and thorough manner.

This book will be of interest to all who at times are confronted with the responsibility for making recommendation concerning individuals who find themselves in difficulty because of this condition.

Joseph S. Skobba, M.D.

Rosenfield, Leonard S., M.D., and Makeover, Henry B., M.D., **THE ROCHESTER REGIONAL HOSPITAL COUNCIL**, The Commonwealth Fund, Harvard University Press, Cambridge, Mass., 1956, 204 pp., \$3.50.

This is a report by the Institute of Administrative Medicine of Columbia University School of Public Health on a program organized in 1946 to provide "assistance in planning hospital facilities: promulgation of approved procedures: development of joint administrative practices: development of consulting services: organization and administration of a continuous education program for physicians, dentists, and hospital personnel."

This book is well written and will be of considerable interest to any person interested in the philosophy of "regional hospital councils." However, it records little evidence that the funds and efforts expended in the formation and support of the Council have been justified.

The Council was organized to serve the areas in the

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

immediate vicinity of Rochester, New York. There is evidence that considerable study was made and much effort was expended to integrate the hospital services in the various counties. In addition to the planning was the development of administrative practices, consulting services and educational programs that, presumably, would make for more efficient hospital services. Theoretically, such a program has much to offer the area which it serves. Practically, such a program is not likely to find universal support in this country. It takes away much of the initiative of hospital boards and communities to develop the type of services which the community leaders feel that they need.

Hospital planning, as an example, showed that Council-supported projects added only 167 new beds during the eight year period, although the services of the Council in hospital planning was undoubtedly used by some of the hospitals which did not participate in the Council program.

The program of joint purchasing also appeared to be a failure on a regional basis although some of the smallest hospitals may have profited some by these services. The services of a consultant in clinical pathology were discontinued and the consultant services in dietetics were also not in demand. On the other hand, it appears that the programs for medical record librarians was far more successful than in any other field, probably because of the extreme shortage of trained personnel and the desire of all hospitals to make improvements in this phase of their service.

One notable failure of the Council was in the field of community and trustee education. Apparently no effort was made to work with the departments of Public Health in the development of community resources to meet the Public Health needs. Improvement in nursing education was probably one of the most successful projects of the Council. Real efforts were made in nurse recruitment, development of post-graduate training, and also in the development of practical nurse training.

The educational program for physicians apparently was a failure. This was to be expected in that the program for physician post-graduate education was "handed down from the top." Apparently the physicians themselves had very little opportunity to have the educational programs planned in accordance with what they felt were their needs and, too, it appears that the program was not sponsored and directed primarily by the medical schools.

This report and evaluation, presumably unbiased, would appear to be the final word on the development of hospital councils since the Rochester Council was one of the first experiments in this field. It demonstrates rather clearly that in spite of a liberal subsidy by the Commonwealth Fund over a period of eight years, the Council will most likely become one of the host of community parasitic agencies which are the remnants of present and recent past social experiments in the field of health, education, and welfare. Its failure to gain the complete support from the communities and the agencies which it was created to serve demonstrates rather conclusively that regional hospital planning, even when heavily subsidized by outside agencies, does not meet the approval of either the community or the hospitals.

Rufus F. Payne, M.D.

Wolstenholme, G. E. W., and O'Connor, Cecelia M. (Editors); **INTERNAL SECRETIONS OF THE PANCREAS**, Ciba Foundation Colloquia on Endocrinology, Vol. 9; Little, Brown and Company, Boston, 1956, 292 pp., 100 ill., \$7.00.

This book presents an excellent review of the morphological relations of the known pancreatic structures to the endocrine activities of the pancreas. Specific articles present current concepts regarding the alpha cells and glucagon production, the beta cells and insulin production. Although the field is changing rapidly and our knowledge is expanding, this type of monograph is excellent for bringing the physician up to date on current theory and comprehension of the subject. The structure and metabolism of glucagon as well as insulin are reviewed by authorities in the field.

This book is hardly one that every practitioner will want; on the other hand, the specialist in metabolic disease will profit by having it in his library, and certainly it should be on the shelf of an up-to-date hospital library.

Walter Lyon Bloom, M.D.

Maximow, Alexander A. (deceased), and Bloom, William; **TEXT-BOOK OF HISTOLOGY**, W. B. Saunders Company, Philadelphia, 1957, 628 pp., \$11.00.

This has been a text-book of high standing and the new edition certainly lives up to the reputation of its predecessors.

There are now 1082 illustrations of which 265 are in color. Many electron micrographs are included and help to explain many cytological points. Their presence indicates the revolution through which cellular morphology is now passing and certifies that in the next ten years the greater proportion of histology and cytology will deal with submicroscopic structure. There is little doubt that this will add considerably to our understanding of cellular physiology. Maximow and Bloom show some beautiful illustrations of mitochondria, of the Golgi zone of cells, of the endoplasmic reticulum of cell junctions, cilia, etc. and have modified the text to explain the significance of what is seen. The basic histology is of course largely unchanged but is given a more functional slant.

It is probably not necessary for a student to know histology in quite the detail with which it is prescribed here—but as a work of reference and for giving him a general understanding of cells and tissues the book is excellent. For a graduate student it is superb. There is an excellent index which adds considerably to the value of the book.

Geoffrey H. Bourne

Massie, William A., **MEDICAL SERVICES FOR RURAL AREAS, THE TENNESSEE MEDICAL FOUNDATION**, Harvard University Press, Cambridge, Massachusetts, 1957, 68 pp., \$1.25.

The booklet is the story of a program to improve the health service for one group of communities in rural Tennessee. It is an eye-opener, and although the exact procedures used here may not be applicable to areas of Georgia, certain principles are established which could be a guide to similar programs in any area.

The area presented in this booklet is in the mountains of Northeast Tennessee above the Norris Dam area. It is a secluded valley of about one hundred square miles and a population of around 6,000 persons, mostly coal

miners and their families. At the time of the study, it was discovered that organized health service was practically unknown in the whole valley area and the services that were available were not utilized at all. Most of the services that were provided were by inadequately trained and unlicensed doctors. There were very little social and cultural opportunities in the area; however, it was noted that the people in the valley were intelligent and self-respecting and that there was no evidence of excessive drinking or lawlessness.

A liaison committee was sent into the area to survey the needs there, and it was decided to assign the duty of doing something about this particular area to the Tennessee Medical Foundation. Through the help of a grant of the Commonwealth Fund, a survey was made in the summer of 1953 of the valley area and a comprehensive report was presented to the Tennessee Medical Foundation Board and its committee on health and medical care. The State Medical Society made \$10,000 available for use in this and other projects, and the Commonwealth Fund was then petitioned for an additional grant to help in carrying out plans, and this was granted.

After the survey was made in the community it was decided in the early part of 1954 to establish a clinic. An effort was made to obtain contributions locally, both cash and materials for the development of the clinic, and as the work progressed a physician was obtained and arrangements were made for a dentist to come in one day a week for consultations. Following this much more interest developed in the clinic.

There was some difficulty at first in getting patients to come to the clinic, and many amusing incidents are related that the doctor encountered in his first days there. Many of these incidents would be recognized by other physicians who have located in rural areas.

In spite of economic depression in the valley the use of the clinic services steadily grew. During the first 12 months the doctor collected \$8,418.00, and the Foundation supplemented this salary to some extent. After six more months of practice Dr. Meeks was collecting sufficient funds to meet the income which had been guaranteed to him by the foundation. The wide-

spread interest that was aroused by the valley caused *Life Magazine* to send two representatives to take pictures and the story appeared in the November 29, 1954, issue.

Other projects of the Tennessee Medical Foundation are also described in this booklet, although most of the booklet is spent on the spectacular Pruden Valley story. The foundation has been instrumental in the development of medical centers in other areas of Tennessee and also in helping communities to plan for hospitals and clinics. In some areas the foundation was able to persuade local people that their need was not for a hospital, but rather for a clinic or medical building. In other areas they have helped the communities to secure the services of a doctor by pointing out to them the things that the community needed to do to attract doctors. The Foundation's efforts served several very excellent purposes and provides a good program of guidance for other state medical societies. They have helped in the curbing of costly mistakes that are often made in communities by unwise planning, and they have helped in planning, the development of material facilities to fit the long range needs of the community. To develop the type of service best suited to each community's health requirements and economic resources and to teach the people and the medical profession to work together with dedication toward alleviation of suffering and long-range improvement in the health of the people in each community is the direction of the program. This program is based on the acceptance of the fundamental philosophy that organized medicine can and should assume an active role in the medical affairs of local communities and shall stand in the position to materially assist and insure the provision of good medical care to the people of the State of Tennessee.

There are several appendices in the book. The first one is a charter of the corporation of the Tennessee Medical Foundation. There is a copy of the form that was used in the survey that was made in Pruden Valley. There is an interpretation of some of the survey findings of this particular area including the food practices of the children and the dental findings in the schools and an appendix on the development of consultant services to rural clinics and hospitals through the efforts of the Foundation. The Editor of the book, William A. Massie, is the Chairman of the Health Committee of the Council of the Southern Mountains, and was formerly the field secretary of the Tennessee Medical Foundation.

J. L. Walker, M.D.

CANCER EDUCATIONAL PROGRAM EVALUATED

THE GEORGIA DIVISION of the American Cancer Society has appointed from among the members of its Board of Directors a committee composed of Dr. Everett L. Bishop, Atlanta, Honorable Charles L. Gowen, Brunswick, Mr. Roby Robinson, Atlanta, and Joseph B. Cumming, Atlanta, as Chairman, to evaluate the effectiveness of the educational campaign of the Cancer Society.

The most effective way in which this committee can function is to ascertain from the members of

the medical profession the experience that they have had in dealing with patients who either had or feared that they might have cancer. The committee is anxious to know if patients seeking medical advice have been influenced in any way by the literature or other publicity promoted by the American Cancer Society. Doctors are urged to keep this in mind when examining patients and to send their findings to JOSEPH B. CUMMING, M.D., 909 Marion Building, Augusta, Ga.

MAG COUNCIL MEETING, SEPTEMBER 14-15

GEORGE R. DILLINGER, Thomasville, Chairman of the Council of the Medical Association of Georgia, called the meeting of the Council to order at 2:05 p.m., September 14, 1957, at the Academy of Medicine, Atlanta, Georgia.

Officers and Councilors present were: W. Bruce Schaefer, Toccoa, President; Lee Howard, Sr., Savannah, President-Elect; Hal M. Davison, Atlanta, Immediate Past-President; T. A. Peterson, Savannah, First Vice-President; Hugh J. Bickerstaff, Columbus, Second Vice-President; Chris J. McLoughlin, Atlanta, Secretary-Treasurer; Thomas W. Goodwin, Augusta, Speaker; Charles T. Brown, Guyton, First District; George R. Dillinger, Thomasville, Second District; W. G. Elliott, Cuthbert, Third District; J. W. Chambers, LaGrange, Fourth District; J. G. McDaniel, Atlanta, Fifth District; Henry H. Tift, Macon, Sixth District; D. Lloyd Wood, Dalton, Seventh District; James M. Hicks, Brunswick, Eighth District Vice-Councilor, acting for Councilor F. G. Eldridge; C. R. Andrews, Canton, Ninth District; and Addison Simpson, Jr., Washington, Tenth District. Vice-Councilors present included Charles S. Jones, Atlanta, Fifth District; Ralph W. Fowler, Marietta, Seventh District; Paul T. Scoggins, Commerce, Ninth District; and David R. Thomas, Augusta, Tenth District. AMA delegates present were: Eustace A. Allen, Atlanta; and Spencer H. Kirkland, Atlanta. Committee Chairmen present were: John P. Heard, Decatur, Public Service Committee; G. Lester Forbes, Atlanta, Blood Banks Committee; David Henry Poer, Atlanta, Hospital Relations Committee, Distinguished Service Award Committee of Council, and Special Lectureship Committee; Don F. Cathcart, Atlanta, Special Polio Committee. Also present were Messrs. Krueger and Kiser of the Headquarters Office; Mr. John Arndt, Headquarters Office Medicare Administrator; and Miss Helen Hendry, Managing Editor of the *Journal*.

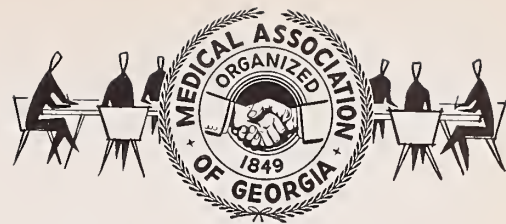
Following the Invocation given by Chairman Dillinger, the minutes of the Council Meeting of June 15-16, 1957 were read and approved as were the minutes of the Executive Committee of Council Meeting, July 21, 1957.

Reports of Council Committees—Reports of the Council Committees were given as follows:

Distinguished Service Award—Distinguished Service Award Committee Chairman David Henry Poer introduced a preliminary report with recommendations for discussion concerning the provisions for an Association Distinguished Service Award. After discussion Dr. Poer reported that a final draft of the Committee's recommendations would be submitted at the next Council meeting.

Annual Session—Annual Session Committee Chairman Henry Tift reported on the MAG Specialty Society Chairman meeting, July 28, Macon, at which time section meetings of the forthcoming 1958 MAG Annual Session Program, April 27, 28, 29, 30, 1958, Macon, Georgia, were approved by his committee as follows: Sunday, April 27

2:00 p.m. to 5:00 p.m.—*Section Meetings*: (1) Pediatrics, Orthopedics, and Radiology Joint Section, (2)



the association

Psychiatric and General Practice Joint Section; 5:00 p.m. to 6:30 p.m.—*MAG House of Delegates*; 6:30 p.m. to 7:30 p.m.—*MAG House of Delegates Social Hour*

Monday, April 28

9:00 a.m. to 12:00 noon—*General Session "G. P. Day;"* 12:00 noon to 1:00 p.m.—*General Session Business Meeting*; 2:30 p.m. to 5:00 p.m.—*Section Meetings*: (1) Orthopedics, Surgery, Anesthesiology, Pathology, and Industrial Surgery Joint Section (Trauma), (2) Medicine, Neurosurgery, Radiology and EENT Joint Section (Hypertension); 5:00 p.m. to 8:00 p.m.—*Alumni Dinners*; 8:00 p.m. to 9:30 p.m.—*General Session "G. P. Day" Reconvened*

Tuesday, April 29

9:00 a.m. to 12:00 noon—*Section Meetings*: (1) Medicine, Chest, Diabetes and EENT Joint Section, (2) Obstetrics & Gynecology, General Practice and Anesthesiology Joint Section; 12:00 noon to 1:00 p.m.—*General Session Lectureship*; 2:30 p.m. to 5:00 p.m.—*Section Meetings*: (1) Obstetrics & Gynecology, Pathology and General Practice Joint Section, (2) Surgery Section; 6:30 p.m. to 7:30 p.m.—*Social Hour*; 8:00 p.m.—*MAG President's Dinner*.

Wednesday, April 30

9:00 a.m. to 11:30 a.m.—*MAG House of Delegates (2nd Session)*; 11:30 a.m.—*General Session Business Meeting (2nd Session)*

Certain Specialty Society business meetings and Specialty Society luncheons reported by Dr. Tift, and this was received by Council as information.

Institution-Physician Relations—Mr. Krueger presented a request from Institution-Physician Relations Committee Chairman Eldridge report to defer his report until the December meeting of Council, and this deferment was approved.

Finance Committee—Finance Committee Chairman J. G. McDaniel reported on the monthly statement of the Association budget and expenses. This report was received for information. Dr. Daniel then requested the Council to approve the re-investment of certain funds of the Association which had been invested in bonds now matured. It was voted to approve the investment of the following Association funds: \$5,000—Peachtree Federal Savings and Loan, Atlanta; \$5,000—DeKalb County Federal Savings and Loan, Decatur; and \$5,000—First Federal Savings and Loan, Atlanta.

Councilor Apportionment and Re-districting—Councilor Apportionment and Re-districting Committee Chairman Thomas Goodwin reported that he is preparing for Council a re-districting plan whereby societies with over 100 members will be more actively represented in the Council. As this project must be considered by the Constitution and By-Laws Committee and would not go into effect until one year after its first reading in the House of Delegates, Dr. Goodwin emphasized that this was merely a preliminary report. He further stated that he would have additional data for the consideration of Council in the near future. This report was accepted for information.

Medical School Courses—Medical School Course Committee Chairman McLoughlin reported on progress in devising a curriculum for the seniors at both of the medical schools in Georgia on the "Art of Medicine." He further reported that this was being considered by the Deans of both medical schools and he discussed the subjects covered in the course. The report was received for information.

Medicare Report—Mr. John Arndt, MAG Medicare Administrator, presented statistical data of the Dependents Medical Care Act. Mr. Arndt discussed certain problems in connection with the administration of Medicare, namely (1) renegotiation of contract, February 28, 1957; (2) problem of incomplete claim forms, and (3) personnel problems including Review Board expansion. At this time Review Board Chairman, Charles S. Jones, reported on the operation of Medicare by Indiana and Florida under a no-fee schedule system and stated that MAG was in the process of obtaining information from those two states and that he would report further on the matter at the next meeting of Council.

Professional Conduct Committee—Secretary-Treasurer Chris J. McLoughlin reported on an August 4, 1957 meeting of the MAG Professional Conduct Committee concerning the Barrett-Athens, Georgia problem. Dr. McLoughlin presented the report of the Professional Conduct Committee on this matter, and it was voted to approve this report subject to the approval of Association Attorney, Mr. Dunaway, and to send a copy of this report to the patient involved in the case.

AMA Public Relations Conference—Public Service Committee Chairman John P. Heard reported on his attendance at the AMA Public Relations Conference, August 28-29, 1957, Chicago. Dr. Heard emphasized that the conference was extremely worthwhile and that his Committee will implement many of the ideas advanced at the conference. Dr. Heard also commented on the success of the MAG participation in the conference program.

Special Polio Committee—Special Polio Committee Chairman Don F. Cathcart gave a final report on the activity and results of the Committee activity as follows:

"In January 1957 I attended the A.M.A. Polio Conference in Chicago as the delegate from the M.A.G. On my return a resume report was made to Dr. Hal Davison, then president of the M.A.G., and in this

report certain suggestions and recommendations were made. I stated at this time that if the people of Georgia were to be encouraged to use this valuable asset to preventative medicine that very strong medical leadership would be very essential to promote a successful program and campaign.

"Dr. Davison appointed me as General Chairman of the M.A.G. Salk Polio Committee, and without further ado we began to formulate plans which we hoped would lead to ultimate success. A chairman and co-chairman were appointed to serve in each district, and on February 34th, 1957, a meeting of this committee was held here in the Academy of Medicine. The State representation was excellent and following talks by Dr. Davison and Dr. Friedewald, the problem was presented in detail. Each district chairman and co-chairman working together were to appoint county or group county chairmen and they in turn were to set up their own local organizations. The district groups met and decided upon the best approach to the problem according to local conditions and local problems. It was pointed out that there would be no all-out movement to throw this mass immunization program into the hands of city or county health organizations. It was strongly stressed that if at all possible it should be handled by the private practitioners, but that if the doctors were apathetic and failed in their duty to the public then health groups would be called upon.

"It was planned to start the campaign throughout Georgia in mid April or early May with a proclamation by Gov. Marvin Griffin and this was arranged. We were in constant communication with the various chairmen and every detail had been worked out when the supply of vaccine became non-existent. The chairmen were then instructed to slow up the fine work which had been started and mark time until sufficient vaccine could be made available. Every effort was made to encourage wholesale and retail druggists and the doctors to order the material, for it was only through legitimate requests of this nature that the vaccine could be obtained. Somewhat later small amounts of the vaccine began to dribble into Georgia, but it was not until mid June that we were able to re-promote the inoculation campaign.

"I am very proud of the response of the people of Georgia to the efforts of their doctors in each district and county. To date about 300,000 doses of commercial vaccine have been given, but still this does not nearly represent the fulfillment of our ultimate goal. Statistically about 42 per cent of the people in our state have had one or more injections, but the job is by no means completed.

"Julian P. Price, Chm. A.M.A. Committee on Poliomyelitis, in August, 1957 states that 48 million people in the U. S. A. need second or third injections and that another 41 million have not received any vaccine at all. These figures if broken down percentage wise would place Georgia rather low in the list of States, but the work is still going on. If a letdown becomes eminent the campaign should certainly be re-activated this fall and winter.

"I more than appreciate all of the help I have had in this work and particularly wish to thank Christopher McLoughlin, then Chm. M.A.G. Public Relations Committee who helped immeasurably in what success eventually was obtained. Henry Poer, then Sec. of the

M.A.G. gave us much timely advice and counsel. Mr. Krueger and Mr. Kiser and the office force of the M.A.G. were always very helpful and cooperated to the fullest extent. Again my thanks to all."

Council Chairman Dillinger congratulated Dr. Cathcart on his activity in this area, and the report was received for information.

Hospital Relations—Hospital Relations Committee Co-Chairman David Henry Poer reported on the activity of an August 11, 1957 Hospital Relations Committee meeting held in Macon, Georgia. Dr. Poer stated that the committee recommended that the Medical Association of Georgia should ascertain hospital professional standards, the Georgia Department of Public Health should ascertain certain hospital physical standards, and the Georgia Hospital Association should ascertain hospital administrative and management standards in a program of accreditation for hospitals under 25 beds. Dr. Poer emphasized that this proposed accreditation was not a police action, but rather an educational program to set up certain minimum standards for under-25 bed hospitals. A sub-committee was appointed to work on this project. Kirk Shepherd and Rafe Banks, Jr., were appointed liaison members of the Council Physician-Institution Relations Committee; Walter E. Brown, James R. Paulk, and Addison Simpson, Jr., were appointed to a sub-committee on recruitment of para-medical personnel; Milford B. Hatcher, D. Henry Poer, Rafe Banks, Jr., Herbert D. Tyler, and H. S. Goodwin were appointed members of a sub-committee to meet in liaison with the Georgia Hospital Association officials. The committee also discussed the need for liaison with the Georgia Association of Hospital Governing Boards. Dr. Poer stated that his committee would meet in November in Moultrie.

Blood Banks—Blood Banks Committee Chairman G. Lester Forbes reported on the communication from the Georgia Tuberculosis Association requesting MAG-State Department of Health Sponsorship of a conference on blood banks. This conference would initiate a study of the over-all blood program in Georgia. After discussion of this request, it was voted to study the problems of blood banks. It was recommended that Dr. Forbes call a meeting of his Blood Banks Committee with these other agencies invited to attend to study these problems further before sponsoring a statewide conference in the Association's name.

AMA Delegates Report on "Heller Report"—AMA Delegate Eustace A. Allen reported on the AMA "Heller Report" which encompasses numerous recommended changes in the executive, administrative, and physical function of the American Medical Association. This "Heller Report" will be voted on by the AMA House of Delegates, and Dr. Allen explained the suggested organizational changes in full to the Council.

Hospital Care Council—President W. Bruce Schaefer, member of the Hospital Care Council for the MAG, reported on the recent meetings of this council in planning for county responsibility of the indigent hospital care of patients within the county. Dr. Schaefer read a communication from the council on medical service of the American Medical Association inviting the MAG to send a representative to an October 20-21, 1957 meeting in Chicago, at which time the problems relating to the vendor payment public assistance medical care programs under P. L. 85-110 will be discussed with

the Bureau of Public Assistance of the Department of Health, Education and Welfare. It was voted to send a representative with his expenses paid by funds from the reserve fund.

At this time Chairman Dillinger recessed the September 14 Council meeting.

CHAIRMAN OF COUNCIL GEORGE DILLINGER called the reconvened September 14-15 meeting to order at 9:05 a.m. September 15, Academy of Medicine, Atlanta, Georgia.

Georgia Plan—Background on certain Georgia Plan problems was given by David R. Thomas, Chairman, and Charles S. Jones, Co-Chairman of the Insurance Board. Specific problems discussed were Georgia Plan specifications held invalid by the Insurance Commissioner's office, and it was voted to refer this problem back to the Insurance Board for later recommendation to Council.

MAG Committee Chairman Meeting—Chairman of Committee Chairmen T. A. Peterson reported on the September 13, 1957 meeting of the MAG Committee Chairmen. He stated that 19 out of 29 Standing and Special Committee Chairmen reported on their activity and stated that said report would be published in the *Journal*. He advised the Council that Association Committee activity was at a high point, and it was recommended that a future meeting be held to check on the action planned by these Committee Chairmen.

Nursing Shortage—Mr. Krueger reported a communication received from the Georgia State Nurses' Association which informed the MAG President that the Executive Board of the Georgia State Nurses' Association took action on the resolution passed by the MAG House of Delegates regarding the nursing shortage and the formation of a commission therein. The Council commended the Georgia State Nurses' Association for their activity and interest in this field.

Rural Health—Rural Health Committee Chairman J. Lee Walker reported on the activity of his committee citing the following projects: Appointment of an advisory committee to the Rural Health Committee; recruitment of paramedical personnel; Junior-Senior Day at both medical schools; emphasis on educating public to have a family physician; medical school courses on the "Art of Medicine;" physician placement bureau; preceptorships at both of the Georgia medical schools; weekly news column for weekly news papers on medical topics; insurance pamphlet educating the public on health insurance; data on phosphate poisoning in agricultural sprays to be distributed to physicians as a diagnostic aid; health record cards and personal and family histories for the public; film library for interested agencies; emphasis on establishing chaplain service in hospitals. Chairman Dillinger emphasized the Council's viewpoint of the worthiness of these projects and it was voted that the Council wholeheartedly supports setting up a technician's training course in Atlanta.

Report of Special MAG Attorney—Special MAG Attorney Mr. Francis Shackelford reported on the negotiation with the Board of Regents to date; the recent AMA Judicial Council Hearing, September 7, 1957, Chicago; and the Richmond County Medical Society representation by the MAG Special Attorney at this hearing.

Unfinished Business—Chairman Dillinger called for

unfinished business and Charles R. Andrews, Jr., Ninth District Councilor, expressed his appreciation to Council for their sentiment during his recent accident.

New Business—Chairman Dillinger then called for new business which was transacted as follows:

Professional Liability Insurance—Insurance Board Co-Chairman Charles Jones reported on the progress to date on the MAG-St. Paul Mercury Professional Liability Program. He reported some 1600 Association members enrolled at the end of a two and one-half year period since the program's inception. He further reported that there were five suits for professional liability filed during this year period of which two have been settled. He also reported that there were 17 potential claims on file during the period of the program. Dr. Jones went into statistical detail on the coverage of physicians by St. Paul.

Lectureship Committee—Special Lectureship Committee Chairman David Henry Poer discussed the agreement between the Medical Association of Georgia and the Citizens and Southern National Bank of Atlanta concerning the Abner Wellborn Calhoun Lectureship.

"This agreement made in duplicate this the 17th day of April, 1948 by and between Medical Association of Georgia, a Georgia corporation, hereinafter called Trustor, and the Citizens and Southern National Bank of Atlanta, a national banking association, hereinafter called Trustee, witnesseth as follows:

"In consideration of One Dollar (\$1.00) and other valuable considerations to the trustor paid, the receipt and sufficiency of which are hereby acknowledged, the trustor hereby gives, grants, conveys, and delivers unto the trustee the personal property of the par or estimated value of 3,473.15, a description of which is enumerated in a schedule hereto attached marked Schedule A, and made a part hereof.

"The said property which is hereby conveyed to the trustee and which is hereafter called the trust fund was obtained from donations to a fund known as the "Abner Wellborn Calhoun Lectureship Fund." The purpose of the donors to the fund was to obtain income each year for the purpose of paying the expenses and honorarium of a speaker each year to address the members of the Medical Association of Georgia.

"To have and to hold said trust fund together with any additions to said fund which may hereafter be made by trustor or by any other person or persons, to the trustee and its successors, for its and their use forever, but in trust nevertheless, as follows:

"1. To invest and reinvest all of the funds of said trust estate in such stocks, bonds, or other securities or in any property which the trustee deems best or advisable whether the investments are of the character permitted by law to trustees or not.

2. The trustee shall use its best judgment in the selection of securities for and in the care of the properties belonging to the trust estate, and it shall not be held liable for any loss by reason of any accident, mistake, or error of judgement made by it in good faith in the exercise of said trust.

"3. From the net income of the trust estate the trustees shall each year pay to any person or persons such sum or sums as the trustee may be directed to pay by the Secretary-Treasurer of The Medical Association of Georgia, meeting of the Medical Association of Georgia provided; however, the trustee shall not be required to investigate the purpose for which the payment shall be made but trustee shall be relieved of any liability on account of any

and all payments which the trustee makes upon the direction of the Secretary-Treasurer or trustor.

"5. The compensation of the trustee shall be five per cent of the gross income of the trust fund.

"6. Trustee shall furnish annual statements to the trustor showing the assets, receipts, and disbursements from the trust fund.

"Signed and sealed in duplicate by trustor and trustee by their respective duly authorized officers.

MEDICAL ASSOCIATION OF GEORGIA (Seal)
By (E. D. Shanks) (Seal)

Its Secretary-Treasurer.

CITIZEN AND SOUTHERN NATIONAL BANK OF ATLANTA (Seal)

By (L. H. Parris)
Its Vice President and General Trust Officer."

Resolution

"Whereas, several years ago certain persons made donations to a fund to establish the ABNER WELLBORN CALHOUN LECTURESHIP, it being the purpose of the donors to the fund for the income therefrom to be used each year to pay the fees and honorarium of a speaker or speakers at meetings of the Medical Association of Georgia, and

"Whereas the said fund is being administered by a committee of which at the present time Dr. J. E. Paullin is chairman and Dr. F. K. Boland is treasurer, and

"Whereas the said committee desires that the said fund be turned over to a corporate trustee to be handled for the purpose for which the fund was created;

"So therefore, be it resolved that the said committee be authorized and requested to turn over and deliver to the Citizens and Southern National Bank of Atlanta, Georgia all of the assets of the said Abner Wellborn Calhoun Lectureship Fund, a list of the said assets being attached hereto and made a part hereof.

"Be it further resolved that Dr. E. D. Shanks, a Secretary-Treasurer of the Medical Association of Georgia, be and he is hereby authorized and requested to execute and deliver on behalf of the Medical Association of Georgia as trustor, a trust agreement with Citizens and Southern National Bank of Atlanta, Georgia, as trustee, under the terms of which the trustee is to administer the said fund with any additions thereto, and to disburse the income therefrom at the direction of the Secretary-Treasurer of the Medical Association of Georgia.

"Be it further resolved that the Secretary-Treasurer of the Medical Association of Georgia be authorized to direct the said trustee to make the payments from the income from said trust fund for the purpose aforesaid.

"I, E. D. Shanks, hereby certify that I am Secretary-Treasurer of the Medical Association of Georgia and that the above and foregoing is a true and correct copy of a resolution unanimously adopted by the Council of the Medical Association of Georgia at its regular meeting held on April 27, 1948, Atlanta, Georgia.

"This April 27, 1948.

(E. D. Shanks)

Secretary-Treasurer."

Dr. Poer then recommended that other lectureships accepted by the Association follow the same pattern and it was recommended that Dr. Poer meet with his committee to accomplish this and the matter be referred back to the full Council for approval at a later date.

Peach Belt Medical Society Membership—Mr. Krueger read a communication from the Secretary of the Peach Belt Medical Society as follows:

"At the July meeting of the Peach Belt Medical Society it was voted unanimously to request you to require members of the Georgia State Medical Association to belong to the local Society within the geographical limits of which they live and practice."

This problem had been referred to Council by the Executive Committee of Council, and it was voted that

all MAG members belong to the county medical society having jurisdiction in the area of their dominant practice except when there is no county medical society in that county, in which case they may belong to the nearest county medical society and that this be further clarified in the Constitution and By-Laws.

Crawford W. Long Memorial—Secretary Chris J. McLoughlin reported on financial responsibility of the MAG for the Crawford W. Long Memorial Museum at Jefferson, Georgia. It was voted to appropriate not more than \$400 for the underwriting of maintenance for the next three or four months for the Crawford W. Long Memorial Museum, said appropriation to be taken from the reserve fund, and further that future plans to turn the memorial over to another organization be considered and request that Dr. Rumble report to the December meeting of Council on this matter.

AMA Conference on Physicians and Schools—Mr. Kiser reported that the Executive Committee recommended the sending of a MAG representative to the Sixth National Conference on Physicians and Schools, October 30-November 2, 1957, Highland Park, Illinois, and it was voted to send a MAG representative to this meeting and the appropriation for the representative's expenses to be taken from the reserve fund. It was further recommended that on the representative's return, a special committee be appointed to implement Association activity in this field.

Asiatic Influenza—State Department of Health Advisory Committee member and MAG representative William Friedewald reported on his activities in behalf of the MAG. He recommended that a letter be sent to all physicians jointly sponsored with the State Department of Health. (NOTE: Such a statement on Asian influenza was sent to all physicians and to the MAG and county medical society officers telling of the progress that is being made in controlling the distribution of the vaccine according to a priority plan set up by the MAG. In this letter the county medical societies were urged to publicize the priority plan to obtain cooperation of the pharmaceutical houses and others concerned.)

Legislative Committee Report—Legislative Committee Chairman J. Frank Walker gave a resume of his committee's activity and asked for an appropriation of funds from the reserve fund so that his committee could continue their work. It was voted to expend up to \$500 for Legislative Committee activity.

Medical Advisory Committee to the Bureau of Old Age and Survivors Insurance District Officers—A communication was read from the AMA recommending that each constituent state medical association should offer the services of a Medical Advisory Committee to the Bureau of Old Age and Survivors Insurance District Officers.

Site and Date of December Council Meeting—By general agreement, it was approved that the Council should accept the invitation to meet in Valdosta on December 7 and 8, 1957, and further it was approved by general agreement that the Council accept the invitation from Columbus to meet March 15-16, 1958 for the March meeting of Council.

It was voted to thank Drs. McLoughlin, Davison, and Poer, and their wives, for the most gracious hospitality

accorded the Council on the occasion of this meeting.

There being no further business, the Council meeting was the adjourned at 11:30 a.m.

EXECUTIVE COMMITTEE OF COUNCIL, September 14

THE SEPTEMBER MEETING of the Executive Committee of the Council of the Medical Association of Georgia was called to order at 10:00 a.m. Saturday, September 14, in the MAG office, Academy of Medicine Building, Atlanta, by Chairman Dillinger.

Committee members present were: Lee Howard, Sr., President-Elect; Hal M. Davison, Immediate Past President; C. J. McLoughlin, Secretary-Treasurer; George Dillinger, Chairman of Council; J. G. McDaniel, Chairman of Finance Committee. Also present were Edgar Woody, *Journal* Editor, and Mr. John F. Kiser and Mr. Milton D. Krueger of the MAG Headquarters Office.

The minutes of the Executive Committee meeting of July 21, 1957 were approved as read by Mr. Krueger.

Committee Appointments—The first item of business was correction of committee appointments as follows: Milford Hatcher as Chairman, Hospital Relations Committee and David Henry Poer, Atlanta Co-Chairman; George Alexander, Forsyth, on the Rural Health Committee and off Maternal and Infant Welfare Committee.

VA Fee Schedule—Dr. McLoughlin presented background information concerning the MAG proposed fee schedule in regard to the VA Hometown Care Program. Dr. McLoughlin explained that the Veterans Administration wished to extend the present contract to June 30, 1958 and that Dr. Joiner, MAG-VA Committee Chairman, recommended that this extension not be accepted and the new fee schedule be negotiated and put into effect immediately. It was voted to approve the revised MAG-VA fee schedule which had been forwarded to Washington.

Following further discussion, it was voted to notify the VA that the present fee schedule expires September 30, 1957 and the MAG stands ready to negotiate in regard to the new fee schedule prior to that time.

Medical Meeting Calendar—Mr. Krueger discussed a letter from the Georgia Heart Association and other requests concerning the maintenance by the MAG Headquarters Office of a medical meeting calendar, the same to be published in the *Journal*.

It was voted to approve this request and to inform all medical organizations in Georgia that this medical calendar will be kept in MAG Headquarters Office and also published in the *Journal*.

Social Security Advisory Committee—Mr. Kiser discussed a recommendation of the AMA that state medical societies establish advisory committees to district offices of the Old Age and Survivors Insurance Program. This matter was referred to the full Council.

Investigation of MD's Applying for MAG Membership—Mr. Kiser discussed the possibilities of more complete information of applicants for membership in

the Association. Methods used by other states were discussed and it was voted to refer this matter to the Headquarters Office for a definite detailed recommendation at the next meeting.

Report on MAG Professional Liability Program—Mr. Kiser gave a report on the progress of the MAG-St. Paul Insurance Program to date. He pointed out that the program was successful thus far and that the St. Paul Mercury Insurance Company had been extremely cooperative. Approximately 1600 physicians are now covered under the program and the number of potential claims and suits filed was very low. It was recommended that more physicians take advantage of this program. Dr. Davison suggested that MAG continue to promote and inform members of this MAG-sponsored program at district meetings, society meetings, and by other means. This matter was accepted as information.

Personnel Problems—Dr. McLoughlin discussed a request by Mr. Arndt to attend law school in the morning and work in the afternoon and all day Saturdays. After further discussion, it was voted to refer this matter to Dr. McLoughlin for action with complete backing by the Executive Committee.

Cancer Film—Dr. McLoughlin discussed a film produced by the American Cancer Society on "uterine cancer." It was voted to approve this film for private showings to all-male or all-female groups.

Coweta County Medical Society Problem—Dr. McLoughlin discussed a membership problem that had been brought up by Coweta County Medical Society. After discussion, it was voted to refer this matter to the 4th District Councilor.

Crawford W. Long Memorial—Dr. McLoughlin discussed a request from Lester Rumble, Chairman of the Crawford W. Long Memorial Committee, for funds to operate the new Crawford W. Long Memorial Museum in Jefferson, Georgia, for three or four months; these funds to be approximately \$300 or \$400. It was voted to recommend to Council that MAG grant the request, but that future plans to turn the Memorial over to another organization be considered and request that Dr. Rumble report to the December meeting of Council on this matter.

Workmen's Compensation Problem—Mr. Kiser brought up two letters from Dr. Deal in regard to the selection of physicians under Workmen's Compensation Laws. After discussion, this matter was referred to the Industrial Health Committee with the request that this Committee report to the next Executive Committee Meeting.

Resolution From Chamber of Commerce—Mr. Kiser presented a resolution from the Chamber of Commerce commending the Association for its activities in attempting to correct certain inequities in Workmen's Compensation Laws in regard to the employment of handicapped persons. It was decided to inform the State

Chamber of Commerce that MAG would appreciate the presentation of this resolution at the MAG Annual Session, Macon, April 27-30, 1958, and it was recommended that an officer of the State Chamber of Commerce make the presentation.

Peach Belt Medical Society Problem—Mr. Krueger brought up a problem that had been referred by the Peach Belt Medical Society in regard to members of local medical societies belonging to the society in the jurisdiction of their practice. After discussion it was voted to refer this matter to Council and at the same time point out the opinion of Special MAG Attorney Mr. Shackelford in regard to this matter. It was also voted to refer this matter to the Constitution and By-Laws Committee so that the By-Laws of the Association may be clarified as recommended by Mr. Shackelford.

Report of the Journal—Dr. Woody, Editor of the *Journal*, reported on the activities of the official organ of the Association. He reported that the new Managing Editor of the Association had assumed the duties formerly carried out by Miss Porcher and was doing very well. He discussed certain changes in typography and design within the magazine and several matters were recommended. Also discussed was the new feature of the *Journal*—the articles entitled "Medical Grand Rounds."

AMA Conference on School Health—Tom McPherson of Atlanta discussed a conference of the AMA in regard to physicians and school health to be held October 30-November 2 in Chicago.

After considerable discussion in regard to the entire problem of school health in Georgia, it was voted to provide Council with a resume of Dr. McPherson's report with the recommendation that Council consider this important project and as the Medical Association of Georgia does not have a school health committee, it was further recommended that Council appoint such a committee and send a representative to this meeting, since the meeting is held only every two years; funds for this purpose to be appropriated out of the reserve fund.

Finance Committee Report—Dr. McDaniel discussed the budget and pointed out various items. It was voted to charge the MAG Attorney's travel expense incurred in attending the September 7 Judicial Council Hearing in Chicago to legal expenses.

The next meeting of the Executive Committee was set tentatively for Thursday, October 24, Bon Air Hotel, Augusta, at 4:00 p.m.

There being no further business, the meeting was adjourned.

ANNOUNCEMENTS

Fourth Bahamas Medical Conference—Fort Montague Beach Hotel, Nassau, Bahamas, December 1-15, 1957. The conference offers opportunity for vacation combined with an excellent medical program. Lectures and clinics compose the program. Speakers include top medical men from schools throughout the states. Registration fee, \$75. Reservations should be made by writing to Mr. John L. Cota, General Manager, Fort Montague Beach Hotel, Nassau. For further details

write, B. L. Frank, M.D., 1290 Pine Avenue West, Montreal, Canada.

Six Days of Cardiology—Emory University School of Medicine, Jan. 13-18, 1958. Major problems of heart disease will be discussed by members of the Emory University faculty and visiting doctors. Tuition fee, \$100. For further information write to the Postgraduate Teaching Program, Emory University School of Medicine, 69 Butler St., Atlanta 3, Ga.

New York University-Bellevue Medical Center Postgraduate Courses in the month of December, 1957. Courses in the following are offered: Gastroscopy and Flexible Tube Esophagoscopy, Recent Advances in the Diagnosis and Treatment of Poisonings, Infertility, Surgery of the Cornea, Endoscopy: Bronchoesophagology and Laryngology, Pediatric Cardiology. For more detailed information write Mr. Robert Sheffield, N. Y. U. Bellevue Medical Center, New York, N. Y.

Georgia Pediatric Society, 25th Annual Scientific Meeting—Mayfair Club, Atlanta, Ga., October 31, 1957. Speakers include Robert J. Huevner, M.D., Bethesda, Maryland; Waldo E. Nelson, M.D., Philadelphia, Pa.; James B. Arey, M.D., Philadelphia; and W. L. Funkhouser, M.D., Emory University. For further information write Joseph Yampolsky, M.D., Suite 3-c Frank K. Boland Medical Bldg., 101 3rd Street N. E., Atlanta.

American College of Physicians—Current Research in Cardiovascular Disease—National Institutes of Health, Bethesda, Md., Nov. 18-22, 1957. Fees: A.C.P. members, \$30; Non-members, \$60. The course is designed to give the internist a discussion of many of the facets of cardiovascular disease which are under investigation at the present time. 10 hours will be devoted to a presentation of Vector Methods of electrocardiographic interpretation. For further information write Mary E. Atkinson, Registrar, 4200 Pine Street, Philadelphia 4, Pa.

The American College of Physicians Postgraduate Course—Cardiac Arrhythmias—University of Pennsylvania Graduate School of Medicine and Philadelphia General Hospital, Auditorium, Mills Bldg., 1-3, 1957. Fees: A.C.P. members, \$30; Non-members, \$60. The course is designed especially for internists and cardiologists. It aims to cover the present status of cardiac arrhythmias from the standpoint of pathologic physiology, electrocardiography, and the clinical aspects. Emphasis will be placed on the diagnosis and differential diagnosis of the various arrhythmias and the present concepts of therapy. For further information write Mary E. Atkinson, Registrar, 4200 Pine Street, Philadelphia 4, Pa.

Cruise Congress of Hemisphere Ophthalmologists—On board the *S. S. Queen of Bermuda*, February 1-14. The itinerary includes a day each in San Juan, Ciudad Trujillo, Kingston, Port-au-Prince, and Nassau. Meetings will be held on shipboard and in port cities with the local societies of ophthalmologists. Programs include free papers, symposia, motion pictures, seminars, and exhibits. For details and/or reservations write Mr. Leon V. Arnold, 33 Washington Square West, New York 11, New York.

Post-doctoral Fellowships in Research and Clinical Allergy—The American Foundation for Allergic Diseases. Two years. 1st year, \$4,500; 2nd year, \$4,750; laboratory and travel expenses for two-year period, \$750. Candidates must be graduates of approved medical schools and must have completed one or two years of the graduate training required as a preliminary to certification by the Boards of Internal Medicine or Pediatrics; they are to divide their time between research and clinical training, and in the second year 10 or 15 per cent of a candidate's time might be devoted to teaching. Request for applications should be sent to Colin M. MacLeod, M.D., Professor of Research Medicine, University of Pa., 820 Maloney Clinic, 36th and Spruce Streets, Philadelphia 4, Pa.

1958 Prize Essay Contest—Sponsored by the American College of Chest Physicians. The contest is open to undergraduate medical students throughout the world. Essays may be written on any phase of the diagnosis and treatment of chest diseases. First Prize, \$500; Second, \$300; Third, \$200. For application and further information write to the American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

DEATHS

JOSEPH A. COYLE, 63, of Dublin, died unexpectedly at the VA Hospital in Dublin, August 15, 1957. A native of Avelon, Pa., Dr. Coyle received his M.D. degree from the University of Pittsburgh Medical School. He interned at Mercy Hospital and had a private practice at Braddock, Pa., after which he did residency in orthopedic surgery at the Children's Hospital in Pittsburgh.

Since 1949, Dr. Coyle had been Chief of Orthopedic Surgery at the VA Hospital in Dublin. He was a fellow of the American College of Surgeons, a fellow of the American Academy of Orthopedic Surgeons, and a diplomate of the American Board of Orthopedic Surgery.

He was a member of the Laurens County Medical Society, the American Medical Association, the Alleghany County Medical Society in Pittsburgh, and the Medical Association of Georgia.

Survivors include his wife, the former Margaret Burch of Pa.; one daughter, Mrs. Patricia Burns of Pittsburgh; one son, Phil Coyle, a student at the University of Georgia; one sister; and three grandchildren.

WALTER REYNOLDS McCOY, 70, of Folkston, died in the Georgia Baptist Hospital in Atlanta on August 31, after a brief illness.

Dr. Reynolds was a graduate of Emory University and served his internship at Georgia Baptist Hospital. He had practiced medicine in Folkston for the past 30 years.

A member of the American Medical Association, the Medical Association of Georgia, and the Ware County Medical Association, Dr. Reynolds was a past president of the Folkston Lions Club, a member of the Folkston City Council, an active member of the Baptist Church where he served on the board of deacons, board of

DEATHS / continued

trustees, and the finance committee. He was also a former state senator.

Survivors include his wife; his mother, Mrs. J. W. McCoy of Birmingham, Ala.; three sons, John D. and and Robert of Folkston, and Bill McCoy of Atlanta; two daughters, Mrs. Wallace Martin and Mrs. John Teleford of Atlanta; and one sister, Mrs. J. L. Shirley, Birmingham.

WILLIAM L. MOSS, Athens, died August 12, at the age of 81.

A native Athens, Dr. Moss received degrees from the University of Georgia and Johns Hopkins Medical School and did postgraduate medical study abroad. The major portion of his medical career was spent in teaching and research work at Johns Hopkins, Yale University Medical School, and Harvard Medical School.

Dr. Moss is well known in the medical profession for his contributions in the field of blood classification, tropical medicine, and hemorrhagic diseases. The Moss method of blood grouping for transfusions is known throughout the medical world.

During his medical career, Dr. Moss was in charge of a Harvard Expedition to Peru in 1916. He was a member of scientific expeditions for the study of tropical medicine in Central America in 1914 and two expeditions to Santo Domingo in 1920. In 1928-29 he was a member of Crane-Field Museum expedition to the Pacific, and he later participated in the Crane-Peabody Museum expedition to New Guinea.

Dr. Moss served overseas in the Medical Corps of the A.E.F. during World War I, holding the rank of Colonel. He is listed in WHO'S WHO in American Men in Science.

CECIL G. MOYE, Dublin, died August 25, at the age of 60.

Born in Oconee, Dr. Moyer was reared in Brewton and Dublin. He was a member of the Masonic Lodge, a Shriner, a member of the Christian Church, and former chairman of the Laurens County Board of Education. He was also one of the original directors of the Farmers and Merchants Bank.

He was graduated from the Georgia Military College, Milledgeville, and the Atlanta Medical College, now Emory University.

Surviving are his wife, the former Clara Duggan; three sons, Cecil G. Moyer, Jr., of Charlotte, N. C., Thomas D. of Knoxville, Tenn., and Victor C. of Palatka, Fla.; and one daughter, Mrs. A. R. Ellis of Thomasville.

WALTER ELLIOTT SIMMONS, Metter, died August 30, at the age of 70.

Dr. Simmons attended the University of Georgia Medical School where he was an honor graduate. He had practiced medicine in Candler County for the past 48 years. A member of the Medical Association of Georgia, Dr. Simmons was past president of the Tri-County Medical Society. He was a past president of the Southern Pediatric Seminar, Salluda, S. C. and served as chief of staff of the Candler Hospital from the date of its organization until last year.

Dr. Simmons was a former mayor of Metter, a member of the governor's staff, and a deacon of the Metter Baptist Church. He was a member of the Metter Kiwanis Club, the American Legion, and the Masonic Lodge.

Survivors are his wife, Mrs. Maude Maxwell Simmons; three daughters, Dr. Kathryn S. Lovett, Augusta; Mrs. Josephine M. Denmark, Savannah; and Mrs. Lillian S. Bell, Douglas; one brother; and nine grandchildren.

DUNCAN DEVANE WALKER, 72, of Macon, died last August 23, following a long illness. Dr. Walker was born in Warsaw, N. C. and moved to Macon in 1914 from Philadelphia, Pa. where he had attended school.

Dr. Walker was a member of the Bibb County Medical Society, the American Medical Association, and the Medical Association of Georgia. He was a past member of the Macon Exchange Club, a member of the Elks, a veteran of World War I, and a member of the American Legion.

Survivors include his wife, the former Helen Parker; one son, Dr. Duncan Walker; one daughter, Mrs. R. A. Clark; one grandchild, Helen Walker Clark, all of Macon; and one sister, Mrs. David L. Woodward of Warshaw, N. C.

ROBERT FORNE WHEAT, Bainbridge, died September 5, at the age of 77.

Dr. Wheat received his Doctor of Medicine degree from the University of Tennessee Medical School and was associated with the Riverside Hospital and Clinic in Bainbridge for many years. He was a member of the Medical Association of Georgia, Southern Medical Association, and the Decatur-Seminole County Medical Society. He served for a number of years as a member of the State Board of Medical Examiners and was chairman of the Decatur County Board of Health.

Dr. Wheat was also active in civic affairs. He was a trustee of Shorter College at Rome, chairman of the loan committee of the board of directors of the First State National Bank, and chairman of the Bainbridge board of trustees for the city schools.

Survivors include a son, Osler C. Wheat of Jacksonville, Fla.; three daughters, Mrs. John T. McCall, Jr., of Rome; Mrs. W. A. Wardel of Charlotte, N. C., and Mrs. Carl S. Fryer, Jr., of Quincy, Fla.; one brother; and three sisters.

SOCIETIES

At a recent meeting of the BIBB COUNTY MEDICAL SOCIETY, Shannon Mays and Thomas Hall conducted a symposium on the tranquilizing drugs. At the same meeting Asiatic influenza and the proposed plan of the Air Force to immunize all civilian employees at Warner Robins were discussed.

Members of the COBB COUNTY MEDICAL SOCIETY were guests at a buffet supper and lawn party given by Dr. and Mrs. Edward S. Marks of Marietta in honor of Dr. and Mrs. Charles Underwood and Dr. and Mrs. W. Bruce Schaefer of Toccoa.

PERSONALS

First District

W. H. BEDINGFIELD and H. I. CONNER of Vidalia have announced that Frank T. Robbins will be associated with them at the Conner-Bedingfield Hospital for several months. Dr. Robbins graduated from Emory University School of Medicine and served his internship at the Medical College of Virginia Hospital, Richmond, Va. He was assistant surgical resident at St. Louis University Hospital and was chest surgery resident at Emory Hospital.

C. G. HAMES, Claxton, was recently invited to visit the Harvard University School of Public Health and to present a summary of his work in heart disease. From Boston Dr. Hames flew to Philadelphia for conferences at Wyeth Research Laboratories where he observed investigations of the relations of stress to the causes of heart disease.

LEE HOWARD, JR., Savannah, was recently appointed chairman of the Urban Advisory Committee of that city.

Second District

PAUL W. LUCAS, Tifton physician, was guest speaker at a recent meeting of the Tifton Pilot Club. Dr. Lucas' topic was on the importance of astronomy in the modern age.

WARREN A. TAYLOR, Thomasville, spoke on the values of the newly established blood bank in Thomasville at a meeting of the local Rotary Club.

Third District

W. G. ELLIOTT, Cuthbert, recently attended the medical sessions of the Georgia Tuberculosis Association and the Georgia Trudeau Society in Macon. Dr. Elliott is a member of the executive committee of the Tuberculosis Association. From Macon, Dr. Elliott left for Savannah to attend the Ninth Annual Meeting of the Georgia Heart Association.

T. SCHLEY GATEWOOD, Americus, was guest speaker at the Annual Ladies' Night of the Baptist Men's Brotherhood.

R. C. PENDERGRASS of Americus, who is a recognized authority on the Confederate prison at Andersonville, gave a talk to the local Rotary club on the controversial story of the old prison.

Fourth District

E. A. DANEMAN, Waycross psychiatrists and neurologist, addressed the Civic Woman's Club of Waycross at a meeting at the Happy Hours School for mentally retarded children. Dr. Daneman spoke on the general subject of the problem of mental retardation among children.

James Emmett Collins is now associated with JAMES W. SMITH at the Smith Clinic in Manchester. A native of Manchester, Dr. Collins attended Mercer University, the Medical College of Georgia in Augusta, and was a

resident in surgery at Columbia Hospital, Columbia, S. C.

J. R. THOMAS, Griffin, Health Commissioner for the Tri-County district, was guest speaker at a recent meeting of the Barnesville Rotary Club.

Fifth District

Five Georgia doctors were among the speakers at the September meeting of the State Orthopedic Society held in Atlanta. These were RICHARD E. KING, ROBERT P. KELLEY, E. B. DUNLAP, JR., and THOMAS GOODWYN, of Atlanta, and HIRAM KITE of Decatur.

MILTON F. BRYANT, Atlanta, has been awarded a first prize by the Georgia Heart Association for his paper "Experimental Evaluation of Replacement Grafts in the Venous System." This paper will be published in the AMA Archives of Surgery.

HAL M. DAVISON, Atlanta, spoke on the benefits of organized medicine at a recent meeting of the Hawkinsville Rotary Club.

The members of Kappa Sigma whose names appear in *Who's Who in America* are pictured in the September issue of "The Caduceus of Kappa Sigma" and among the doctors appears the picture of MURDOCK EQUEN of Atlanta.

GUY O. EVERHART, Atlanta, has recently opened offices at the Briar LaVista Dental Building, 1596 LaVista Road at Briarcliff.

J. WILLIS HURST, Emory University School of Medicine, moderated a panel discussion at the Ninth Annual meeting of the Georgia Heart Association.

J. H. KITE, Decatur Orthopedic Surgeon, was main speaker at a September meeting of the Savannah Scottish Rite Bodies.

ARTHUR J. MERRILL, Atlanta, has recently been appointed temporary chairman of a coordinating committee for Emory University and Grady Hospital. Other members of the committee are ARTHUR P. RICHARDSON, J. D. MARTIN, BRUCE R. LOGUE, ELLIOTT SCARBROUGH, WALTER R. THOMAS, FRANK WILSON, CARL C. PFEIFFER, THOMAS J. ANDERSON, JR., and JOHN E. BECK.

At the Georgia Vocational Rehabilitation Staff Conference the following doctors were featured on the program: HAROLD McDONALD, Atlanta; J. Z. McDANIEL, Albany; W. B. SCHAEFER, Toccoa; B. L. SHACKLEFORD, Atlanta; HARRY M. McALLISTER, Atlanta; W. D. JARRATT, Macon; E. F. WAHL, Thomasville, and CHARLES E. IRWIN, Atlanta.

Sixth District

Psychiatrists T. G. PEACOCK and R. W. BRADFORD of Milledgeville and H. D. ALLEN of Allen's Invalid Home recently testified before a special legislation committee on mental health and hygiene in Atlanta.

PERSONALS / continued

A. A. COLE has been appointed medical director and director of intern and resident training programs at the Macon Hospital. Dr. Cole succeeds CHARLES L. RIDLEY who resigned last July.

CHARLES B. FULGHUM, Milledgeville, was named president-chief of staff of the Baldwin County Hospital at a recent election of officers. At this same meeting, WILBUR M. SCOTT, Milledgeville, was elected vice-president and CURTIS F. VEAL, Milledgeville, Secretary.

A barbecue was held recently to honor CHARLES L. RIDLEY, SR., of Macon, who has retired as Bibb County physician after 25 years service.

R. J. WALKER, Macon, participated in a panel discussion at the joint conference of the Georgia Tuberculosis Association, the Georgia Trudeau Society, and the Georgia Conference of TB Workers which was held in Macon. Dr. Walker discussed the new methods of case finding, TB control, and the relationship of public workers and volunteer agencies.

Seventh District

Dr. and Mrs. LUTHER G. FORTSON, Dr. and Mrs. THOMAS B. SHARPE, and Dr. and Mrs. NOAH D. MEADOWS were hosts at a dinner given in honor of 13 new doctors in Marietta and Smyrna and their wives.

D. M. CORNETT, who has practiced in Lafayette for 11 years, has left to go to Spartanburg, S. C. where he will become associated in practice with Irvin H. Trinchler.

JOHN H. CROSS of Rome is the new president of the Georgia Trudeau Society, it has been announced.

VIRGINIA HAMILTON MALEY, Cartersville, was the guest speaker at a recent meeting of the local Lions Club. Dr. Maley spoke on "Tuberculosis Control in Bartow."

EDWARD S. MARKS, Marietta, has announced the association of Charles R. Underwood with him in the practice of general surgery.

Eighth District

Five Valdosta physicians were featured on a recent luncheon program of the local Rotary Club with discussions of the advances of present-day medicine. Doctors addressing the group were VAN B. BENNETT, JOYCE F. MIXSON, JR., RICHARD K. WINSTON, G. J. AUSTIN, JR., and BENNETT G. OWENS. F. G. ELDRIDGE introduced the speakers.

G. W. BARKER, of St. Mary's, has announced that John R. Doster has joined him in the practice of medicine. Dr. Doster, formerly of Newnan, was graduated from the Medical College of Georgia at Augusta and interned at Duval Medical Center, Jacksonville, Fla.

THOMAS W. COLLIER, Brunswick, has announced that Ben T. Galloway has become associated with him in the practice of general surgery and medicine.

WILLIAM E. HARDIN, Waycross, is the new chief of the Ware County Heart Clinic. A member of the clinic staff since 1955, Dr. Hardin succeeds Ivey Jacobs as chief.

The JOURNAL regrets to announce the death of Mrs. Joseph Huff Penland of Blairsville, mother of J. E. PENLAND, Waycross.

Maxwell Felton Hall, Jr., is now associated with NEAL F. YEOMANS, Waycross, in the practice of radiology. Dr. Hall graduated from Emory University School of Medicine where he later served his internship and residency in radiology.

Ninth District

GEORGE T. NICHOLSON, Cornelia, has announced the removal of his office from 414 Wiley Street to 469 N. Clarkesville Road.

W. BRUCE SCHAEFER, Toccoa, was among the honored guests at the patron's dinner for the "Three Faces of Eve" World Premiere held at the Bon Air Hotel, Augusta.

Dr. and Mrs. ED T. WATKINS of Ellijay were honored recently on the second anniversary of the local hospital bearing their name.

Tenth District

WILLIAM E. BARFIELD, Augusta, recently presented a paper before the London Academy of General Practice and the Ontario Academy of Medicine in London, Ontario.

GOODLOE Y. ERWIN, Athens, was elected President of the Georgia Heart Association for the coming year at the Ninth Annual Meeting in Savannah. Dr. Erwin is a charter member of the Georgia Heart Association and is a former chief of the Athens Heart



HARDMAN AWARD PRESENTATION—J. W. Chambers, center, Fourth District Councilor from LaGrange, is pictured with Mrs. Chambers as he received the Hardman Award at the September Council Meeting in Atlanta. Left to right are Hal Davison, George R. Dillinger, Dr. and Mrs. Chambers, and W. Bruce Schaefer. Dr. Chambers was named by the 1957 House of Delegates to receive the Hardman Award for his outstanding contributions to organized medicine as Chairman of the Constitution and By Laws Committee, Councilor for many years and Chairman of Council.

A two-day postgraduate course

gastroenterology

emory university school of medicine, november 8-9, 1957

Program

FRIDAY, NOVEMBER 8

esophagus

- 8:30 a.m. *Esophageal Disorders of Clinical Importance*—Dr. Franz J. Ingelfinger.
9:10 *The Surgical Management of Hiatal Hernia*—Dr. William Van Fleit.
9:30 Question and Answer Panel

peptic ulcer

- 9:45 a.m. *Physiology, Pharmacology and Choice of Drugs*—Dr. Ingelfinger.
10:25 *Problems of Upper G.I. Bleeding*—Dr. Spalding Schroder.
10:45 Coffee Break
11:00 *Post-Gastrectomy Syndromes*—Dr. Thomas E. Machella.
11:30 *Exfoliative Cytology*—Dr. John T. Galambos.
11:50 Panel Discussion on *Gastric Ulcer*—Drs. Ingelfinger, Machella, J. D. Martin, Ted Leigh and Schroder (with case presentations).
1:00 p.m. Lunch
2:00 *The Milk-Alkali Syndrome*—Dr. Julius Wenger.
2:30 Question and Answer Panel

gallbladder

- 2:45 p.m. *The Healthy and the Diseased Gallbladder*—Dr. Machella.
3:30 Intermission
3:40 *The Radiologic Examination of the Biliary Tract*—Dr. Richard Elmer.
4:00 *Post-Cholecystectomy Syndromes*—Dr. Machella.
4:20 Question and Answer Panel

common sense in use of special diets

- 4:35 p.m. Discussion by Dr. Ingelfinger.

SATURDAY, NOVEMBER 9

pancreas

- 8:30 a.m. *Acute and Recurrent Pancreatitis*—Dr. Machella.
9:00 *Tests of Pancreatic Function*—Dr. Joseph Hilsman.
9:20 *Present Status of Surgery for Pancreatitis*—Dr. Jack Thompson.
9:40 *Diagnosis of Cancer of the Pancreas*—Dr. Ingelfinger.
10:00 Question and Answer Panel
10:15 Coffee Break

symposium on abdominal pain

- 10:30 a.m. *Mechanisms and Interpretation*—Dr. Ingelfinger.
11:10 Panel on *Functional G. I. Disorders*—Drs. Napier Burson, Hilsman, Ingelfinger, McClaren Johnson and Machella.

intestines

- 12:20 p.m. *Acute Diarrheal Disorders*—Dr. Schroder.
12:40 *Classification of Malabsorption Syndromes*—Dr. Wenger.
1:00 Lunch
2:00 *Differential Diagnosis and Treatment of Cancer of the Colon*—Dr. Sam Wilkens.
2:30 *Complications of Diverticulitis*—Dr. J. D. Martin.
3:00 Panel Discussion—*Regional Enteritis and Ulcerative Colitis*. Drs. Tom Anderson, Brit Gay, David Hein, Ingelfinger, Machella, W. C. McGarity and Wyman Sloan, Jr. (with case presentations).
4:15 Intermission
4:20 *The Irritable Colon Syndrome*—Dr. Machella.

Apply now. Registration fee: \$30.00

PERSONALS / continued

Clinic. He is past-president and past-chairman of the Board of Directors of the Northeast Georgia Heart Association. He was instrumental in the establishment of the clinic in Athens and in the development of the entire heart program in the Northeast Georgia Chapter area.

HARRY T. HARPER, Augusta cardiologist, spoke

to a recent meeting of the Augusta Exchange Club on the subject of heart diseases.

JOHN B. O'NEAL, Elberton, has announced that Lloyd C. Davis of Ellijay will be associated with him in the practice of medicine. Dr. Davis is a graduate of the Medical College of Georgia and has practiced for one year in Knoxville, Tenn.

KENNEY FOUNDATION AWARD

THE Sister Elizabeth Kenny Foundation announces a continuance of its post doctoral scholarships to promote work in the field of neuromuscular diseases. These scholarships are designed for scientists at or near the end of their fellowship training in either basic or clinical fields concerned with the broad problem of neuromuscular diseases.

Kenny Foundation Scholars will be appointed

annually. Each grant provides a stipend of from \$5,000 to \$7,000 a year for a five-year period, depending upon the Scholar's qualifications. Candidates from medical schools in the United States and Canada are eligible.

Inquiries concerning details should be sent to: Dr. E. J. Huenekens, Medical Director, Sister Elizabeth Kenny Foundation, 2400 Foshay Tower, Minneapolis 2, Minnesota.

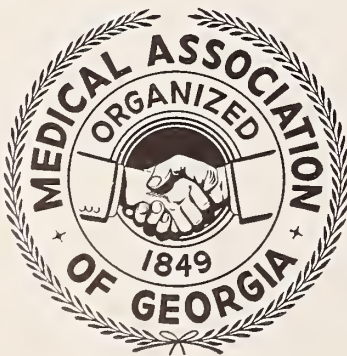
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Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

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COVER

In this dramatic shot taken at the Children's Hospital in Philadelphia, *Journal* photographer, Ted F. Leigh, M.D., discarded the usual flash bulb technique and employed only available lighting for the picture. A Rolleiflex camera set at 1/50 second at f4 was used with Tri-X film.

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RADIOACTIVE IODINE IN TREATMENT OF PULMONARY INSUFFICIENCY

*Clinical aspects of this useful application of radioisotopes in therapy are discussed.
The recent literature is reviewed.*

B. SHANNON GALLAHER, *Augusta, Georgia*

A RENEWED INTEREST in chronic diseases of all types has been noted in recent years, probably because of decreasing mortality and advancing age of the general population. Diseases causing chronic pulmonary insufficiency, in particular, have received increasing attention as evidenced by the fact that literature on the subject has now become voluminous. We shall discuss our clinical experiences with radioactive iodine (I^{131}) therapy in the management of this frustrating group of diseases since the origin of our work in 1954. This was previously reported in preliminary form.¹

Medical thyroidectomy by the use of radioactive iodine (I^{131}) for the treatment of pulmonary insufficiency is based upon a single rationale which was first pointed out by Blumgart et al,^{20, 21, 22, 23, 24} and Jaffe^{25, 26} and used by them in the treatment of angina pectoris and intractable congestive failure. The aim in using I^{131} thyroidectomy for either heart disease or chronic lung disease is to decrease the oxygen requirements of the individual so that al-

though the basic pathologic condition remains unchanged he will experience a decrease in or disappearance of his symptoms because the arteries of the heart are required to carry less oxygen or the alveolar membrane of the lung is required to diffuse less oxygen into the arterial blood.

This is a report of work on forty-three patients to date. Its emphasis will be the evaluation of the degree of clinical improvement, the physiological findings will be presented elsewhere in detail. Table one shows data regarding age, sex, color, number of times treated, duration of observation, and the total dose of I^{131} per patient.

Table two gives a detailed breakdown of primary diagnoses as well as accessory diagnoses. It should be pointed out that most patients had more than one disease entity as is indicated by the figures. Thus, many patients had chronic bronchial asthma which had begun in childhood in addition to pulmonary emphysema and cor pulmonale. Two patients had silicosis with the typical diffusion defect expected in any case of pulmonary fibrosis, and neither of these showed any real evidence of associated emphysema, either clinically, by x-ray, or by pulmonary function studies.

The metabolic status before and after treatment is seen in Table three, as well as total number and

Presented by Dr. W. F. Hamilton at the meeting of the American Physiological Society in Medford, September 6, 1955, and at the meeting of the American Heart Association in New Orleans, October 23, 1955.

This work was made possible by a grant from the Atomic Energy Commission.

The authors are indebted to Dr. W. F. Hamilton, Dr. Lois T. Ellison, Dr. Robert G. Ellison, and Dr. William F. Hamilton, Jr., for their assistance in this work.

RADIOACTIVE IODINE / Gallaher

percentage of excellent, good, fair, or no clinical improvement. Further details regarding patients who expired while on the study can also be seen in Table three.

All patients were thoroughly evaluated, both clinically and by laboratory studies. Chest x-rays, electrocardiograms, measurements of venous pressure, and total circulation times were obtained on all patients. The decision as to metabolic status

TOTAL NUMBER OF PATIENTS = 43

	WHITE	COLORED
FEMALES	4	0
MALES	38	1

	MAXIMUM	MINIMUM	AVERAGE
AGE	77 yrs.	17 yrs.	53.4 yrs.
DURATION OF OBSERVATION	30 mos.	3 mos.	13.9 mos.
NO. OF TIMES TREATED	5	1	1.6
TOTAL PATIENT DOSE OF I ¹³¹	76 mc.	14 mc.	33.5 mc.

Table 1: Data regarding age, sex, color, number of times treated, duration of observation, and total dose I¹³¹.

was based on I¹³¹ uptake studies, blood protein bound iodine (PBI), serum cholesterol, and clinical picture. Patients were studied at two to three month intervals for the first year, and at four to six month intervals thereafter.

All forty-three patients were severe pulmonary

DIAGNOSES

BRONCHIAL ASTHMA	18
BRONCHIECTASIS	8
PULMONARY EMPHYSEMA	40
SILICOSIS	2
PULMONARY TUBERCULOSIS	Active----- 1 Inactive----- 6 Total Tbc----- 7
COR PULMONALE	13

ACCESSORY	DIAGNOSES
ARTERIOSCLEROTIC HEART DISEASE	4
ESSENTIAL HYPERTENSION	2
KYPHOSCOLIOSIS (POTT'S DISEASE)	1
HYPERTHYROIDISM	3
CARCINOMA OF LARYNX	1
CARCINOMA OF BLADDER	1
MALIGNANT MELANOMA	1
BRONCHIAL ADENOMA	1

Table 2: Detailed breakdown of primary diagnoses as well as accessory diagnoses.

cripples, having been incapacitated for a period of months to years. Only a few were able to work at all, and these held a desk job, either part time or full time, and one was able to set type eight hours

a day.

All patients had received standard forms of therapy, including bronchodilators of every description, given orally, intravenously, rectally, and by nebulizer. Many had been maintained on antihistamines, expectorants, antimicrobial agents, cortisone, ACTH, oxygen, and several had required repeated bronchoscopy to rid their tracheo-bronchial trees of viscid secretions.

Since such chronically ill patients were chosen, many with associated extreme weakness, cachexia, and general debility, there was little hope that worthwhile results would be large in number or striking in degree. The most that could be expected was palliation, and it is to be emphasized that this therapy is not to be used with the thought in mind of replacing standard forms of management, but rather should be used as an adjunct to the established methods with the hope that perhaps some medications may be discontinued or diminished.

After a few weeks or months, clinical evidence of myxedema appeared, following which each patient was given sufficient thyroid to maintain him at the lowest level at which he gained maximal relief from pulmonary disease and minimal relief from the symptoms of myxedema. This usually required 15 to 30 milligrams of desiccated thyroid extract daily, but in few cases, the dose required to relieve symptomatology of myxedema was enough to cause the recurrence of dyspnea.

Contrary to the experience of Blumgart and his co-workers who noted that following the administration of I¹³¹ a third of the patients developed signs

METABOLIC STATUS

BEFORE TREATMENT			AFTER TREATMENT		
	NO.	PERCENTAGE		NO.	PERCENTAGE
HYPOTHYROID	1	2.32 %	HYPOTHYROID	34	79.07 %
EUTHYROID	32	74.42 %	EUTHYROID	7	16.27 %
HYPERTHYROID	5	11.63 %	HYPERTHYROID	1	2.33 %
UNCERTAIN	5	11.63 %	UNCERTAIN	1	2.33 %

CLINICAL RESULTS

	NO.	PERCENTAGE
NONE	17	39.53 %
FAIR	10	23.27 %
GOOD	7	16.27 %
EXCELLENT	9	20.93 %

TOTAL NUMBER OF DEATHS = 5

CAUSES	PROBABLE ACUTE HEART FAILURE----- 3
	UNKNOWN ----- 2
	KNOWN TO BE MYXEDEMATOUS ----- 3
	KNOWN TO BE EUTHYROID ----- 2

Table 3: Data regarding patients who expired during study.

of a transitory thyroiditis,⁴ there was only one such patient in this series who developed a very mild thyroiditis approximately two weeks after therapy. This might have been true in our series because the

largest single dose of I^{131} given was 26.6 millicuries, whereas as high as 56 millicuries per dose were used in Blumgart's work.

In subsequent reports⁴ of management of these patients, modifications of the original technique have appeared, and most investigators, including Blumgart, Jaffe, and Beierwaltes, now recommend the use of more numerous and smaller doses of I^{131} , to avoid transitory hyperthyroidism, if possible.

No discernible evidence of hypothyroidism occurred until some six weeks to six months following the administration of therapeutic doses of I^{131} . The onset of incipient hypothyroidism was usually detected by evidence of slight fullness or puffiness of the face, a report by the patient that dyspnea had become diminished, rise in serum cholesterol, decrease in blood protein bound iodine, and a diminished uptake by the thyroid of a tracer dose of I^{131} , measured twenty-four hours after its administration. As myxedema progressed, the patient noticed lethargy, weakness, weight gain, drying of skin, paresthesias, constipation, aching of joints, hoarseness with lowering of the voice, stuffiness of the nose and ears with perhaps even a diminution in auditory acuity, irritability or depression. These discomforts were usually minimized with the use of desiccated thyroid extract.

It was not felt that any patient in this series developed serious complications as a result of "myxedema heart disease," for in no instance was an increase in cardiac silhouette noted, nor did congestive failure occur that could not have been explained on another basis.

Evaluation of Treatment

In an attempt to evaluate the results of treatment, one is confronted by the fact that no very good objective test is available for determining the actual degree of improvement. Therefore, it was necessary in most instances to rely on the patient's subjective statements regarding his improvement and to use simple tests of exercise tolerance, such as allowing the patient to ascend one flight of stairs under the physician's observation. Also important in evaluation of therapy was whether improvement was experienced in mental outlook, ability to care for oneself or to return to some sort of gainful occupation, reduction in required drugs and whether these improvements outweighed the disadvantages of the hypothyroid state. It is admitted that psychological help given these patients could perhaps, at least partially, explain some of the improvement when it did occur; however, efforts to keep this factor at a minimum were made by limiting the number of visits, the investigators seeing the patients only when they returned for followup as previously outlined; their local physicians cared for them in the intervals

between follow-up visits.

The criteria for evaluation of therapy was as follows:

(1) *Excellent*—This denoted that the patient showed marked improvement over pretreatment status, there being either no recurrence of symptoms or a marked decrease in the severity of dyspnea. Many of these patients were able to return to gainful occupations.

(2) *Good*—This denoted definite improvement in the severity of dyspnea on the same amount of activity as before treatment.

(3) *Fair*—This denoted only minimal improvement over pretreatment status, but in many instances, this was enough improvement so that patient was able to get out of bed every day, dress himself, feed himself, and move about the house.

(4) *None*—This indicated no improvement over pretreatment status.

The clinical results obtained in this series, with approximately 60 per cent receiving excellent, good, or fair results and 40 per cent receiving no clinical improvement, are not as good as the previously reported results.¹ This probably indicates that initial improvement following I^{131} therapy is better than that seen after long term followup. This closely parallels the results of Hurst's work⁵ in which he found, after having accumulated in excess of fifty cases, that the late results were not nearly as good as the earlier results. Our clinical results do not compare quite as favorably with Bercu's and Mandell's¹² or Beierwaltes'⁷, but none of these investigators have reported a long term follow-up since the initial preliminary report. Miller¹⁶ has also carried out a similar study, but at last communication did not feel that definite conclusions could be reached, because although he had noted some subjective improvement in patients in whom myxedema had been induced, he had also noted improvement of a similar degree and incidence in patients who received I^{131} but did not develop myxedema.

Tables four, five, and six show, in brief summary, the clinical picture of representative cases which have been graded as having received good, excellent, and no clinical improvement, respectively. Table four shows the final evaluation of a patient previously described who for a year and a half following therapy was able to climb a forestry tower eighty feet tall, twice a day, after he had been totally unable to work for five years prior to treatment; however, when last seen, this patient had been forced to give up his job, not because dyspnea was the primary difficulty, but because weakness and lethargy resulting from myxedema did not allow enough energy to carry out this activity. In attempting to increase patient's dose of thyroid, there was a recurrence of dyspnea, and

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he felt that he was more comfortable with his myxedema than with his dyspnea, so his dose was dropped back to a maximum of 30 milligrams daily. Patient has been able, however, to continue doing lighter work, so it was felt that although initial excellent improvement had not been permanent he

Dx. (1) Chronic bronchial asthma
(2) Chronic pulmonary emphysema
(3) Bronchiectasis

Duration of observation - 26 mos.
No. times treated - 1
Total dose I¹³¹ - 1-26.6 mc.
Treated - 6/1/54

	Before Treatment (1 ¹³¹)	After Treatment (1 ¹³¹)
SYMPTOMS	(1) Severe dyspnea - 5 yrs (2) Productive cough - 5 yrs (3) Inability to work - 1 yr. (4) Recurrent respiratory infections.	(1) Minimal dyspnea (2) Cough lessened in severity and productivity. (3) Worked as Forestry Look out for 18 mos. (4) Fewer respiratory infections (5) Slight puffiness of face (6) Mild parasthesias (7) Moderate weakness
Exercise Tolerance	Could walk only 100 ft	Ordinary activity
Therapy	(1) Bronchodilators (2) Antimicrobial agents (3) Expectorants (4) Anti histamines (5) Bronchoscopy	(1) Prophylactic Gantrisen (2) Desiccated thyroid 15-30 mg. daily
Clinical Result		Good

Table 4: Patient, 48 years old white male, was able to continue doing light work following treatment though initial improvement was not permanent.

had achieved good clinical improvement in the final evaluation.

Table five shows details of another case, evaluated as having received excellent clinical improvement, but the patient has not returned to gainful occupation because of lack of initiative and complete self-satisfaction in relying on welfare help for his living.

Table six shows a typical example of a patient

Dx. (1) Chronic pulmonary emphysema
(2) Pulmonary tuberculosis, M.A. inactive
(3) Malignant melanoma, rt. preauricular area, excised
(4) Cor pulmonale

Duration of observation - 30 mos.
No. times treated - 2
Total dose I¹³¹ - 45 mc.
Treated 11/19/54 and 1/25/55

	Before Treatment (1 ¹³¹)	After Treatment (1 ¹³¹)
SYMPTOMS	(1) Severe dyspnea - 3 yrs (2) Wheezing - 2 yrs (3) Parasthesias, feet, minimal (4) Decr. temp., feet, minimal (5) Frequent resp. infection (6) Unable to work	(1) Severe dyspnea (2) Wheezing (3) Parasthesias, feet & hands, severe (4) Decr. temp., feet, marked (5) Frequent resp. infections (6) Unable to work (7) Severe constipation (8) Periorbital edema & puffiness of face. (9) Lethargy and weakness (10) Intermittent claudication
Exercise Tolerance	Less than one flight of stairs	Less than one flight of stairs
	(1) INAH and PAS (2) Bronchodilators (3) Antihistamines (4) Sedatives (5) Antimicrobial agents	(1) Bronchodilators (2) Antihistamines (3) Sedatives (4) Antimicrobial agents (5) Desiccated thyroid, 30 mg. daily (6) Laxatives (7) Vasodilators (8) Nebulized expectorants
Clinical Result		None

Table 5: Patient shows excellent clinical improvement following treatment. Failed to return to work because of lack of initiative.

who received no clinical help, and in addition, was made miserable by symptoms of myxedema. Perhaps this occurred because patient's metabolic status before therapy was never very clear, and it is entirely

possible that he was already hypothyroid before being treated. In support of this is the fact that two therapeutic doses of I¹³¹ were necessary to produce the clinical picture of myxedema, suggesting that the thyroid gland was not as avid for the I¹³¹ as are most euthyroid glands.

Out of the total number of forty-three patients in this series, there were five deaths and three of these were known to be myxedematous at the time of death. Since three of these patients expired at home, no autopsies were performed, and it is therefore impossible to be sure of the exact cause of death. However, a note of caution should be interjected because of the more frequent reporting of death as a result of coma in myxedema. Malden,¹³ Karhausen, and Zylberszac,¹⁴ and LeMarquand et al¹⁵ have all reported cases of myxedema coma, with or without hypothermia, causing death and being refractory to therapy once coma had actually occurred. LeMarquand¹⁵ felt that myxedema coma is not a rare occurrence and that it appeared to be

Dx. (1) Chronic pulmonary emphysema
(2) Chronic cor pulmonale (by EKG)
(3) ? Bronchiectasis

Duration of observation - 24 mos.
No. times treated - 1
Total dose I¹³¹ - 25 mc.
Treated - 7/9/54

	Before Treatment (1 ¹³¹)	After Treatment (1 ¹³¹)
SYMPTOMS	(1) Severe dyspnea - 5 yrs (2) Chronic productive cough 5 yrs (3) Weight loss (4) Malaise (5) Recurrent respiratory infections (6) Orthopnea	(1) No dyspnea (2) Diminished cough (3) Weight gain - 30 lbs (4) No malaise (5) Fewer infections (6) No orthopnea (7) Periorbital puffiness, minimal (8) Mild parasthesias
Exercise Tolerance	Could walk only 1/2 block	Could walk one mile
Treatment	(1) Monaldi procedure (1950) (2) Antimicrobial agents (3) Bronchodilators (4) Expectorants	(1) Desiccated thyroid - 15 mg. daily (2) Prophylactic Gantrisen
Clinical Result		Excellent

Table 6: Patient received no clinical help and suffered greatly from myxedema.

irreversible with available therapeutic means. However, as was suggested by him, since the availability of L-Triiodothyronine, perhaps the ultimate outcome of this disease will be improved. There is no real evidence that the three deaths in our series were a result of myxedema coma, but since the exact cause is not known, this is suggested as a possibility in the hope that future workers will be more alert to this complication than we were.

On the basis of this study to the present time, the indications for therapy with I¹³¹ are:

- (1) Dyspnea must be so severe that patient is incapacitated from making a living. He must have at least severe exertional dyspnea, although he may be relatively comfortable at rest.
- (2) Response to a careful regimen of life and adequate medical treatment, using standard measures, has been unsatisfactory.
- (3) The condition must have lasted long enough

that permanent spontaneous improvement is unlikely.

(4) There must be no signs of hypothyroidism, and I^{131} uptake studies must be within normal limits, or in the hyperthyroid range.

(5) Patient must have demonstrated willingness to cooperate by following instructions to the letter and by returning as requested for detailed follow-up studies.

(6) Physical examination should show typical findings of pulmonary emphysema and/or fibrosis with either x-ray confirmation, finding of right ventricular hypertrophy, and/or P pulmonale on electrocardiogram or proof of pulmonary insufficiency by pulmonary function studies. Exercise tolerance should be tested, and if after all the previously mentioned studies he shows no evidence of severe incapacity, then patient should not be treated with I^{131} .

Conclusions

- The following conclusions have been reached:
- (1) Probably only about five to eight per cent of all patients with chronic pulmonary insufficiency are candidates for this therapy.
- (2) No patient receiving extrinsic iodides in the form of expectorants, radioopaque media containing iodides, recent use of iodine on cuts and abrasions, etc. should be studied, nor should he receive therapeutic I^{131} for at least four to six weeks after discontinuance of iodides.
- (3) Normal iodine intake must be required with the use of iodized salt so that false high values on I^{131} tracer study will not be obtained as a result of iodine starvation. Those patients maintained on low sodium diets because of congestive failure can probably achieve valid studies if they are required to eat sea food once weekly until two weeks prior to I^{131} tracer study when sea food should be omitted.
- (4) I^{131} should not be used without the full realization that other standard forms of management will probably have to be continued, and it should be offered merely as a palliative measure.
- (5) Full details should be given to each patient emphasizing the fact that I^{131} thyroidectomy is in most instances a permanent thing and full consent of the patient is necessary before I^{131} should be used.
- (6) Generally, it is felt that individuals in the younger age groups show more clinical improvement than those in the older age group, probably because metabolic status in the elderly is commonly in the low euthyroid or slightly hypothyroid range.
- (7) Although I^{131} thyroidectomy is not the final answer to a very serious problem, it is felt that by careful selection of patients, many completely incapacitated individuals can be rendered more comfortable by this treatment. Even a few months of

improvement may mean a great deal to someone who has been fighting for breath to live for long periods of time.

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CEREBRAL ARTERIOVENOUS MALFORMATIONS

A comparison is made between cases treated surgically and those treated medically. Seven illustrated cases are reported.

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THE EVALUATION of patients with convulsive disorders in conjunction with the rehabilitation service of the state is an important medical function. The activity of the program is increasing and with a larger number of patients some of the more uncommon lesions will certainly be encountered. A small facet of the problem of convulsive disorders has been selected for study, namely, the seizure disorders associated with vascular anomalies of the brain. Olivecrona⁸⁻⁹ has described such lesions by saying "a tangle of blood vessels of varying caliber is interposed between the arterial and venous system . . . The tangle of blood vessels . . . may have the anatomic character of arteries or veins; most of the vessels however are undifferentiated and of a pathologic structure."

It has seemed important to establish criteria in our clinic for the diagnosis and treatment in view of the serious potentialities for death and disability inherent in these lesions whether treated or not. While not common except in specialized centers, they may be somewhat more numerous in the chronic epileptic population than is indicated by the rather low incidence of most series. That they are economically important is suggested by their common clinical presentation during active productive years. It is recognized that the number of patients involved is not large but that the physicians responsibility is weighty when confronted with a patient harboring a vascular malformation.

Certain symptoms and signs in epileptics have provided a pattern indicative of the presence of vascular malformations. Mackenzie,⁶ following a study of 50 cases, thought that sequences suggesting angioma or malformation were:

Epilepsy subarachnoid hemorrhage

Hemorrhage epilepsy

Hemiparesis hemorrhage or epilepsy

Furthermore it was his conclusion that "angiomas presenting with hemorrhage tend to be more deeply

placed in the hemisphere than those presenting with epilepsy." Many clinicians have commented on the occurrence of seizures, intracranial hemorrhage, headache, bruit, mental deterioration, various neurologic deficits, intracranial calcification, and increased vascular markings of the skull in association with these abnormalities.³⁻⁴⁻⁵⁻⁷⁻⁸

In former years malformations were encountered during operations for supposed neoplasms. The innovation of cerebral angiography in 1927 provided a method for identifying and evaluating the arterial supply and venous drainage of the blood vessel anomalies. While it has certain inherent hazards angiography has made it possible for the neurologic surgeon to devise and carry out suitable procedures in some patients with intracranial vascular malformations. Nevertheless it is recognized that this variety of lesion presents a formidable surgical problem¹ and one associated with a high mortality and morbidity.

Keeping in mind the needs of patients as to treatment and self support and the requirements of a rehabilitation service, that the patient be capable of rehabilitation and retraining, it is of concern to the physician to offer the soundest evaluation and advice. Over the years the attempts to treat the malformations have varied from admonition that the lesion was completely inoperable²⁻³ through electrocoagulation, radiation, ligation, and excision. With the improvement of surgical technic the indications for operations on these lesions have become more urgent and inclusive. The high death rate from spontaneous hemorrhage, crippling neurologic deficits, and mental deterioration have been emphasized by Olivecrona⁹ and Norlen⁷ as strong indications for operation.

Gould,⁴ Peyton, and French studied 41 cases from the University of Minnesota Hospitals over the period 1935-1954. As a result of the study it was concluded that the disability from uncontrollable sei-

zures, marked mental deterioration, severe hemiparesis or aphasia in addition to a 20 per cent chance of hemorrhage made it imperative that every possible attempt be made to remove or obliterate these lesions. The prognosis of untreated arteriovenous malformations was stated to be very poor.

Of that group of 41, eleven had no operation. Of these, seven died within 48 hours, having been moribund on admission. Of the remaining four, one died in status; one died two years later of hemorrhage; one has aphasia, hemiparesis, mental deterioration; one was not followed.

Robert Hayne⁵ and his associates reported the surgical treatment by excision of six of nine patients with cerebral vascular malformations. There were no deaths in seven cases of spontaneous hemorrhage and no post operative deaths. Seizures had occurred in only two; no instance of mental deterioration was noted. There was a significant neurologic deficit in five and some post operative morbidity in four. A year after operation one of these patients began to have focal seizures, declined to take recommended medication and finally was admitted to hospital in status epilepticus.

The fate of patients who have not been subjected to a definitive surgical procedure has been studied by Hendrik Svien.¹⁵ He considered the cases of 23 patients who had no surgical treatment over the period 1930-1954 and concluded:

1. Intracranial bleeding in itself is a dubious indication for surgery.
2. On the basis of convulsive disorder alone, operation is not justified. The majority of patients were well controlled medically.
3. Progressive hemiparesis developed in a number that corresponded to the mortality rate of surgical removal; that in most cases the neurologic deficit produced by surgery would be almost as profound as that resulting if the lesions had not been treated.
4. Mental deterioration was seen in one case, an experience contrary to that of Olivecrona and Norden.
5. Headache rarely constitutes an indication for surgical intervention.

In the past few years seven patients with cerebrovascular malformations have been of concern to me as to the diagnosis and, in part, the care. Four were treated surgically and three medically. A summary of some of the details is pertinent to this discussion, small though the group may be.

Case Histories

Case One. Male age 33. For the first time in his life this man had a generalized convulsion a few minutes after an interview with his superior. He had

a second convulsion while waiting for an ambulance. Following this he was somewhat confused but had no other deficit. An EEG focal abnormality (slow) was revealed in the right frontal area. Angiography revealed a moderate circumscribed vascular malformation in that area which was removed without residual by the neurologic surgeon. He was placed on anticonvulsant medication and as far as known had no further seizures over three years.

Case Two. Male age 25. He described stereotyped episodes of "numbness" involving his right hand, arm and neck with a march from the fingers to the side of his neck followed by severe headache. No loss of consciousness was reported. Angiography revealed a large superficial parietal vascular malformation. The patient thought his memory was becoming poor and the headache worse and desired surgery. Surgical intervention resulted in uncontrollable hemorrhage and death.

Case Three. Female age 28. About a year previously this woman reported the onset of Jacksonian seizures beginning in the right foot, progressively involving the leg and terminating in unconsciousness. Arteriography demonstrated a rather extensive malformation high in the parietal area on the right. During operative treatment considerable hemorrhage occurred with a resultant severe flaccid left hemiplegia. Post operatively she continued to have rather frequent seizures. She described sensory features as well as motor manifestations. Anticonvulsant medication was partially successful. She had two children later without difficulty.

Case Four. Female age 54. This woman gave a history of having had several major seizures at the age of 14-18 and then having a seizure free period for the next 26 years. Her admission followed a convulsion while she was working. She described the sudden cessation of sound about her, sudden inability to speak and then apparently she had a major seizure. Angiography subsequently revealed a small vascular malformation lying presumably in the left Sylvian fissure. Operative intervention was considered contraindicated and anticonvulsant medication instituted. For over three years she had no further seizures. Skull x-ray had revealed a small area of calcification within the area of the malformation. No bruit was detected.

Case Five. Female age 28. This woman gave a history of recurring seizures since age 18. The frequency was not excessive. There were adverse features but she could not recall the direction of head turning. She was seen in the neurology clinic during her second pregnancy at request of the obstetrician. Skull x-ray (the first incidentally) revealed a small area of calcification in the left frontal area. A bruit could be heard over the left eye. After her delivery

(uneventful) and a few weeks at home she returned for angiography. This revealed a very large vascular malformation in the left frontal area, which was considered as unsuitable for any surgical attack because of its great size. She was sent home on anticonvulsant medication, remained seizure free and subsequently returned to have another child.

Case Six. Female age 14. This girl had been treated for recurring convulsions over several years. She was dull intellectually. EEG studies were reported as diffusely abnormal. X-ray of the skull was normal. Auscultation of head was overlooked. Control of seizures had always been poor. On one of her periodic visits to the neurology clinic a slight change in anticonvulsant medication was ordered. That afternoon the child had a severe headache, became confused, is said to have vomited. When she went to bed nothing unusual was noted. However the mother reported the child was found dead in bed about 4:00 A. M. and blamed the change in medication. A coroner's examination revealed a large vascular mass involving the left frontal area with recent hemorrhage. The lesion was subsequently determined to be a large vascular malformation.

Case Seven. Female age 30. This woman in 1954 had a subarachnoid hemorrhage with a period of unconsciousness of about 24 hours. CSF was bloody. She recovered, and later angiography revealed a right parietal vascular malformation. This was removed and she was discharged without any residual. Approximately a year later after moving to California, she began to have rather poorly described focal

seizures. An EEG focal abnormality was revealed. She refused to take recommended anticonvulsant medication. Several weeks later she was admitted to hospital in status from which she recovered. The exact correspondence of the angiograms of this patient and those portrayed in Hayne's report (Case No. 7) make reasonably certain the same woman is described. No information is available of her state subsequent to July 1956.

Of the seven cases briefly described there was one death postoperatively, one death from spontaneous hemorrhage. There were two patients surgically treated with severe neurologic residuals (hemiplegia plus seizures and severe epilepsy). There was one apparently excellent postoperative result. Two patients treated medically have had no complication of hemorrhage or mental deterioration or severe neurologic defect. Their seizure disorders have been readily controlled.

Dr. Burton L. Wise, now of the University of California has permitted me to mention and show the angiogram of one of his recent patients. This was a young male in his mid-twenties who had a subarachnoid hemorrhage early in 1956. Several months later after a convulsive seizure angiography revealed a small arteriovenous malformation on medial surface of the right frontal lobe just above the cingulate gyrus. This was successfully removed without residual defect. One seizure occurred after operation. The period of follow-up is too brief for further comment at this time.

Discussion

For purposes of comparison details from the published accounts of various series dealing with the

	1895 1925	1928	1941	1946	1948	1949	1950	1951	1953	1953	1954	1955	1956	1956	1957
	Collected	Dandy	Ray	Pilcher	Olivecrona	Norlen	Pilcher	Bassett	Olivecrona	Mackenzie	Scott	Gould	Svien	Hayne	Current
CASES	22	8	6	3	43	10	11	18	96	50	17	41	23	9	7
EXCISION	0	2	0	3	24	10	5	10	60	?	6	15	0	6	4
DEATH - P. O.	0	2	1	0	3	0	1	2	7	?	4	3	0	0	1
FREQ. OF HEMOR. SPONTANEOUS	9	2	0	2	25	6	5	11	48	15	12	24	9	7	1
DEATH FROM HEMOR.	9	0	0	0	1	0	0	0	9	?	0	8	2	0	1
MORBIDITY NON-OPERATIVE	5	3	4	—	—	—	1	—	20	—	5	—	13	—	0
MORBIDITY POST-OPERATIVE	1	1	0	3	11	9	7	6	6	—	0	7	—	4	2

Table 1: Tabulation of details from published accounts of various series dealing with cerebral arteriovenous malformations.

malformations have been tabulated (Table 1). It is realized that some variation in interpretation must be allowed. Under the morbidity figures an attempt was made to record what seemed a significant deficit as interpreted from the published account.

The frequency of hemorrhage is noted and this is an observation of long standing. A corollary of this is that, according to Bassett,¹ the subarachnoid hemorrhage from these malformations is less devastating than that from berry aneurysms which rupture. Morbidity due to the lesion itself could not be derived in seven of the 15 groups. The postoperative morbidity seems rather marked.

As one considers these figures the variability of the groups becomes apparent. In the experience of some physicians hemorrhage is frequent and devastating; in that of others it is frequent but rarely fatal. Mental deterioration is a common finding in some patient groups, but rare in others. In some, seizures are frequent and uncontrollable; in others, frequent initially but readily brought under control.

From the summarized material in the tabulation, it is apparent no hard and fast rules can be set down as to suitable and safe treatment. Each patient will of course be evaluated individually. If hemorrhage has occurred one or more times and the location of the lesion suggests that removal may not result in an intolerable deficit for the patient then surgical excision may be the treatment of choice.

If no hemorrhage has occurred then medical management may be more seriously considered alone, whether or not the lesion is favorably located for excision. In any case if the lesion is so located that an increased deficit will result or an intolerable deficit will be produced by removal, then the treatment should be limited to medical management. In the presence of seizures alone without hemorrhage and without significant neurologic defect that a thorough trial of anticonvulsant medication is indicated.

It seems likely that because of the endless variation that is possible in the formation of these congenital lesions no rigid rules for therapy will ever be possible. A most important part will continue to be played by that intangible "surgical judgment." However it is likely that valuable information may be gained by further study and prolonged follow-up of

more of those patients who for one reason or another are not subjected to definitive surgical treatment.

Summary

1. Reference has been made to urgent need for surgical management of cerebral vascular malformations emphasized by numerous authors over many years.

2. Consideration is given to the report by Svien concerning the fate of patients with arteriovenous malformations who have not had definitive surgical treatment and his conclusions.

3. Brief histories are furnished of four similar patients treated surgically and three patients treated medically.

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RENEWAL OF LICENSES

ALL LICENSES TO PRACTICE medicine must be renewed by December 31, and failure to do so renders the license invalid. Renewal fee is \$3.00 before the 31st and \$10.00 if submitted after that date. Application blanks for renewal will be sent out to each physician by the Joint Secretary, Examining Boards, on December 1. Any doctor failing to receive such a blank should contact the office of C. L. Clifton, Joint Secretary, State Examining Boards, Atlanta, Georgia.

THE ROLE OF HYPOTHERMIA IN SURGERY

*The indication and limitations of this adjunct to general anesthesia are reviewed.
The author's experience during the past four years is discussed.*

PAUL W. SEARLES and DIGBY G. SEYMOUR, *Chicago, Illinois*

THE USE OF hypothermic techniques played an important role in the development of cardiovascular surgery and in the improvement of results of neurosurgery. In these two fields hypothermia has been used successfully because of its inherent ability to accomplish the following:

1. To reduce the need for oxygen in conditions causing hypoxia.
2. To reduce blood pressure or produce physiological hypotension.
3. To reduce operative bleeding, and
4. To lessen the likelihood of shock.

In the field of general surgery there are many conditions in which it is wise or imperative to utilize these same advantages. If hypothermia can be accomplished with relative safety in the seriously handicapped cardiac patient, it can be made even safer for the average patient undergoing other types of surgery in which its advantages can be used.

Historically, the anesthetic properties of cold have been known since the Middle Ages when ice was applied to extremities before amputations. However, it was not until 1951 that the important observations concerning the application of cold for general anesthesia were noted. The term hypothermia as used today is ill-defined. At present it is generally understood that "modified" hypothermia includes temperatures down to 90 degrees Fahrenheit. "Deep" hypothermia is reserved for temperatures below 78 degrees Fahrenheit, today mostly used for experimental animals. As a relative term, "hypothermia" covers that temperature range in between these extremes. The discussion today is primarily concerned with "modified" hypothermia and its role in general surgery.

Clinically, hypothermia can be produced by (1) Cooling of the diverted blood stream, (2) Cold fluids given intravenously, (3) Gastric, intrapleural, and intraperitoneal lavage, and (4) Surface cooling using cold water immersion, cold chambers, ice packs, and a thermal blanket.

In major cardiac centers the cooling is most frequently accomplished by immersion in ice water

tubs. This technique requires many extra personnel and is not as safe as the use of a blanket. The simplest method of producing hypothermia in even the most poorly equipped hospital is to give cold glucose solutions intravenously. The solutions can be pre-chilled in an ordinary refrigerator and are capable of lowering the body temperature from two to four degrees Fahrenheit. Plastic bags filled with ice chips and placed in the axilla and on the groin or legs have lowered body temperature down to 80 degrees Fahrenheit. Rewarming occurs spontaneously with the resumption of muscular activity.

There are several factors that will determine the speed and extent of hypothermia developed using any of the procedures mentioned. Environmental factors include the patient's own body temperature, the room temperature, the effective circulating air velocity, and the room humidity. Certain inherent factors are equally important. The old and the young are profoundly and quickly affected since they are deficient in compensatory mechanisms. There are natural fluctuations in the body temperatures of children; there is lack of insulation; their surface area is larger; and the very young lack the ability to shiver. Muscular activity as manifested by shivering plays a very important role in hypothermic anesthesia. The shivering may be marked or merely occult and seen only with the electrocardiogram. When the body temperature falls, further cooling is normally arrested by shivering. This may increase heat production as much as 400 per cent and increase the demand for oxygen as much as 20 per cent. During anesthesia the shivering must be abolished by deepening the anesthesia or preventing the muscular movement with curare. Postoperatively it is a signal for the administration of oxygen to the patient.

The biological properties of cold are many, but only the important ones will be considered here. On the central nervous system it temporarily produces amnesia, irrational behavior, and unconsciousness. Narcosis ensues somewhere between 90 and 84 degrees Fahrenheit so that no further anesthetic agent

is needed. Cerebral blood flow and cerebral oxygen consumption are reduced in a linear relationship with falls in temperature.

Hypothermia has its most striking clinical effect on the myocardium and circulation. There is a marked fall in both the pulse and blood pressure. This is not a manifestation of heart failure but is due to the reduction of cardiac output. Oxygen consumption is progressively reduced, experimentally amounting sometimes to 85 per cent. The respiratory rate falls. Spontaneous respirations cease at 82.4 degrees Fahrenheit.

Hypothermic effects on the liver and kidney are apparently secondary to the fall in cardiac output. Body metabolism is reduced approximately five per cent per degree fall in temperature.

There is an increase in the bleeding and clotting times, but these lengthened intervals are of no importance and probably lessen the likelihood of thrombosis due to the increased viscosity.

Paradoxically, in spite of the suppression of various body systems, there is no change in resistance and serological defenses to infection.

The chief inherent danger of hypothermia is the tendency to produce cardiac irregularity, commonly ventricular fibrillation. In practice this complication occurs only in the extreme temperature ranges below 84 degrees Fahrenheit and usually only with manipulation of the heart itself. In the modified ranges the chief danger of hypothermia is the overdose of anesthesia in the presence of depressed body function. The temperature can be checked by using a thermocouple device placed in the rectum or esophagus. Actually, for modified hypothermia, a simple chemical thermometer placed in the nares is sufficient, since there are no critical changes occurring in this temperature range.

Our experience with hypothermia began four years ago in cardiovascular cases. We found that a temperature range of 90 to 84 degrees Fahrenheit was suitable for the majority of these. Lower temperatures were only necessary for prolonged open heart surgery. Two years ago we began to use the method for general surgical cases. We felt that the technique would help to reduce the operative mortality and morbidity in certain poor risk patients. We used as our indications prolonged cases such as carcinoma of the esophagus, debilitated and poor risk cases, carcinoma of the pancreas, febrile and toxic cases, and surgical procedures which involved a large blood loss. Records are available on 74 general surgical cases performed under hypothermia.

These cases presented the following variety of pathology:

Gastro-intestinal malignancy	37
Common duct stricture	7

Carcinoma of the pancreas	5
Bleeding duodenal ulcers	4
Ulcerative colitis	3
Miscellaneous	18

There were nine postoperative deaths.

The cause of death was:

Cardiac	3
Renal	2
Pulmonary embolism	2
Infection and toxicity	2

In all of these cases there was clinical evidence before surgery that these complications would likely occur, and the causes of death correspond closely with those anticipated and seen in a series of similar cases using normothermic anesthesia.

The technique employed to obtain hypothermia of 90 to 84 degrees Fahrenheit does not prolong the anesthesia nor necessitate additional personnel. General anesthesia prior to any cooling prevents shivering. A pentothal-gas-anectine induction is followed by intubation on the cart. The patient is then placed on a thermal blanket precooled to 34 degrees Fahrenheit. Surgery is begun immediately. Anesthesia is maintained with a light cyclopropane and oxygen or ether and oxygen mixture. The blanket temperature is reversed when the body temperature reaches two degrees above the expected lowest level required. There is a drift downward in the patient's temperature of two to three degrees after rewarming is begun and must be anticipated. A hypothermic rebound is usually seen postoperatively.

The anesthetic requirements are reduced sometimes as much as two thirds of the expected requirement. The benefit of the reduced anesthetic agent is borne out by the lack of immediate postoperative depression. Patients are awake and alert sooner and are able to cooperate in the stir up regime to prevent postoperative atelectasis.

The decreased blood loss in those patients where the blood pressure was not deliberately lowered is probably secondary to the vaso-constriction. In a review of our cases it was found that one to two pints less of blood was required when compared to a similar group of normothermic patients.

In summary, the technique of hypothermic anesthesia is not difficult. Induction of anesthesia is the same as for normothermic anesthesia. The chief difficulties arise with the onset of cold below the modified range, at which time practically all anesthetic agents can be eliminated. But the relatively safe "modified" ranges allow for all of the advantages of cooling: Mainly, a smooth anesthesia, lessening of anesthetic agents needed, a lessened likelihood of shock, and decreased operative bleeding.

1439 South Michigan Blvd.

A LOOK TO THE FUTURE

A philosophical discourse concerning the future of medicine in our country.

A. C. FURSTENBERG, M.D., *Ann Arbor, Michigan*

WE IN THE health sciences are in big business. People of this country are exceedingly health conscious and are vitally concerned with all of the personnel and agencies dealing with the prevention and cure of illness. Dr. Allen Gregg believes that we are rapidly reaching par with food, clothing, and shelter. When we take into consideration the services of physicians, dentists, nurses, the medical schools, and hospitals with their clerical and technical personnel, pharmaceutical institutions and instrument makers, national societies and foundations concerned with health, Governmental agencies, health and accident insurance companies, we might well be listed on the stock exchange among the top four or five great enterprises of this country. Moreover, we would enjoy unprecedented trading activities because of the public interest in health and their awareness of the effectiveness of all of these persons and agencies concerned with it.

Rapid advances in medicine and the tremendous growth of the health sciences have created an environment in which man's basic existence is reasonably assured for 65 years or longer in this part of the world. The old vital statistics which doomed man to death before he was 40 have been shattered. We in a very large measure are the custodians of this environment. It is within our power to protect and defend its ideals and to fulfill its obligations or to permit it to pass into a period of decadence menacing to health and longevity. But the custodianship of any great enterprise entails obligations and important responsibilities. These must be a major concern of every medical man in a free world. If we are interested in progress, are inspired by our concern for a rapidly increasing population, and have confidence in the miracle of prolonging life and of maintaining it useful and effective, we shall proceed resolutely to meet the challenges which are now before us.

We come face to face daily with that all-important controversial issue which deals with the number of

physicians in this country. Statistics for various purposes and design are presented to us in great abundance by many persons with ethical differences of opinion. One individual, for example, tells us that we have one doctor for every 850 persons in this country; thus we are adequately supplied with medical service. Another informs us that while these ratios may be true now, we are nevertheless facing a serious shortage of medical manpower because of our failure to reckon with anticipated normal mortality losses and attrition of medical men for disability and retirement reasons. I question the validity of all these figures. Frankly, they have me confused. They have succeeded in doing what Stephen Leacock said could be accomplished by any academician addicted to numeration. "If, when delivering a statistical speech," said Leacock, "you observe that some member of your audience is awake and appears to have a gleam of intelligence on his face, throw in a fraction or two and you will promptly put him to sleep." This is precisely what has happened to many of us. Speakers on the subject have thrown too many fractions at us. Yet, I suppose Will Rogers was right when he said, "Statistics are like garbage, when you got 'em you gotta do somethin' about 'em."

A number of influences exist today which call for an increased number of physicians in this country. Our rapidly increasing population and their needs for more effective medical care and preventive services are demanding a greater number of doctors. Medical administrators are asked by laymen in public life and members of the medical profession what steps are being taken to prevent a critical shortage of medical man power and medical educators are asking the question "Where do we go from here?". I am reminded of the story of Father Switala, Dean Emeritus of St. Louis University Medical School. He is a sincere honest man with a deep sense of moral values and a fine sense of humor. Coming from the holy Father, this story has emphasis. Two of his Irish parishioners were discussing predestination in the theological sense. One of them said that he

Presented to the Medical Association of Georgia in Savannah,, April 29, 1957.

believed in preordination of men to everlasting happiness or misery and that when the child was born he was predestined to heaven or to hell and the other Irishman said that he wasn't so concerned about knowing that he was going to hell as he was about knowing, etc.

The United States Bureau of the Census predicts a phenomenal growth of our population in the years ahead of us. Within my memory, the United States had a population of only 75 million. When our last census was taken in 1950 this figure had doubled. Dr. Dudley Kirk, Demographic Director. The Population Council, Inc., believes that by 1980 it may be tripled. It is his opinion that "a reasonable guess of our population in 1980 is 240 million on the assumption of the continuation of present trends in birth and death."

It is important therefore it seems to me for us to know where we are going and get on our way in medicine without further delay. We have two courses to pursue; one, to construct and staff new medical schools, and the other, to increase our present enrollments in the medical schools of this country. I believe that there are valid arguments for doing both, and if these are done in a judicious and orderly manner, we need have no apprehension about fulfilling public demands for medical care and at the same time maintaining high standards of medical education. When human lives are at stake there can be no compromise with that fundamental principle of the highest possible quality of medical service for all groups of our population. We must give quality in medical education our first consideration as we proceed with a program of expansion.

Problem of Distribution

I do not share the concern of our people today in regard to the inadequate distribution of medical manpower. Admittedly it is a crisis in some of our rural areas but migration trends in the United States give promise of solving this problem for the future. Rapid shifts of our population from rural to urban areas are attracting people from farms and villages to the suburbs of metropolitan areas and thence to an "exurbia" which surrounds the suburbs and distributes people from the city over the country-side. The medical profession is a part of this rapid movement and it is within the suburban areas that many hospitals and health centers with excellent facilities for medical practice are being constructed.

The doctor strives for a successful career in his profession. Success for him is in a very large measure evaluated by his ability to practice medicine in a creditable manner and to render a quality of service comparable to that which he has observed during his clinical years in the medical school. He seeks recognition in the medical profession; the admira-

tion and esteem of his fellow doctors, and he knows full well that these attributes are gained not only by dint of effort but also by the availability of modern facilities for the practice of his profession. Adequate and satisfactory distribution of medical service demands that the practice of medicine be made attractive for the doctor and this is being accomplished through the construction of modern hospitals in the suburban and exurban areas of migration. Occasionally the young doctor who is financially encumbered commences the practice of medicine in a small village but strives to abandon it when his finances will permit. Astonished residents in a dilemma cannot understand why the doctor with such a thriving practice departs from their community. To join them is to remain forever is their axiom. Obviously the magistrates and elders of these villages are imbued with the same complacency that prompted someone to place a sign I saw the other day over the gate of a cemetery in Dearborn, Michigan which reads "Entrance only." Construct hospitals and health centers, equip them with x-ray laboratories and other necessary facilities for the practice of modern medicine, and you will draw the doctors to the areas where their services are in demand. This is precisely what is happening today; a trend that gives promise of solving our problem of adequate distribution of physicians in the foreseeable future.

Increase in Specialization

Rightly or wrongly, it is an established fact that specialization in medicine is on the increase. Each year for the past fifty we find a higher proportion of graduates of our medical schools entering full time specialty practice. We decry this trend because we are convinced that the generalist is the backbone of our medical profession today. Educational programs to interest the undergraduate medical students, interns and residents, in the general practice of medicine have been instituted in many of our medical schools, but they have failed to stem the tide of specialization. It's a trend of the times, and while our efforts to influence the young doctor in his early formative period to enter the general practice of medicine may slow the trend towards specialization, we must accept the fact that social and economic pressures and the expansion of our economy are forcing the growth of specialization.

To be specific in the presentation of this problem, I need to call your attention to the following phenomena which have occurred since the turn of the century. In the past fifty years the enrollment in high school has increased ten fold from 700,000 to 7,000,000. In that same fifty years the number of young men and women in the eligible age group (14 to 21), has increased from 12,000,000 to 17,400,000. In that same period the number of students

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in high school or college has increased from 1,000,000 to 9,000,000. Percentage wise, this means an increase in high school from eleven and one-half per cent to eighty per cent in 1950. In that same half century the eligible age group has increased forty-four per cent, while the high school and college enrollment has increased over one thousand per cent.

In simple terms, this trend means that there has been a constant shift of our youth from the labor force to college, and that secondary education is replacing the apprenticeship by which a goodly number of our youth were trained in former years. We are creating new professions by leaps and bounds. No longer are we limited to the physician, teacher, preacher, engineer, and lawyer. We have broadened our pattern of specialization to newer professions, the social worker, scientists, management of men, management of quality control, management of opinion, college trained business men, government career men, economists, architects, journalists, librarians, tool engineers, sale engineers, public relation experts, and on and on.

It is stated that preparation for the newer professions accounted for less than ten per cent of the activity of higher education in 1900, while today it accounts for forty-six per cent of the programs of training in colleges and universities of this country. Does anyone believe that the medical profession has not been a part of this surge toward specialization? The expansion of our economy is demanding more and more people with superior skills in specialized fields and whether we like it or not the medical profession is an integral part of this development.

The young doctor of today is interested in his livelihood: in making a satisfactory living for himself and family. I am unable to reconcile to modern medical practice the time worn tradition that the doctor enjoys starving in his attic. It has always been my observation that a man virile enough to be a good doctor is also a hearty fellow who enjoys his food. Those sensitive souls who talk about one's love of science for science's sake and believe that those engaged in it do not claim an utilitarian value for what they accomplish have never had the administrative experience of a dean. The great men of medicine who have created epochs in the progress of science did not starve in laboratories, at least the court proceedings of their probated estates do not reveal many instances of such a tragic ending.

If I were a medical student today, contemplating the practice of medicine, I would give serious consideration to the migration trend which Dr. Dudley Kirk describes as follows: "In recent years, almost all of the population growth of the United States

has been concentrated in metropolitan areas and within these areas, not in the central cities, but in the so-called "urban fringe" that rings each of our great cities. Four-fifths of the nation's growth between 1950 and 1955 was concentrated in suburbia and beyond in the new "exurbia" where the cities have sprawled into the country-side. Smaller cities and towns outside the metropolitan areas absorbed only five per cent of the national increase, while rural areas lost population."

"The old distinctions between farm and city life in the United States are blurring as the people of the farms move to the cities and cities move into the country-side. Physically the suburbs are absorbing practically all of our population growth. If the present trends continue by 1980, well over half of our population will live in the suburbs of metropolitan areas, and these will have sprawled far beyond their present boundaries. Suburban living is becoming the American way of life."

Three Areas of Medicine

Medicine is taught and fought on three fronts today: in the classroom, in the laboratory, and at the bedside. There is no sharp line of demarcation between medical education, research, and the care of the sick. Each is inexorably dependent on the other.

In the office of the dean, one soon discovers not only that an administrator has three jobs but that these three responsibilities share a common reality, a reality usually and rightfully conceived by the layman to be typical of medicine itself. This is the reality of emergency, of unpredictability, of change.

In looking to the future we shall need to examine the force of this reality in our medical school each year when our budgetary requirements are anticipated. Medical education is enormously expensive. It is estimated that it costs some \$15,000 to \$16,000 to educate a single medical student. I believe we must contemplate even greater outlays in the years to come. Our medical schools budget to the very last dollar. This of course is imperative. Educational institutions must respect the fiscal year. It often happens, however, that the fiscal year fails to respect the unpredictable nature of sickness and health. It is a great source of satisfaction, to say nothing of the feeling of security which is engendered, to know that contingency funds are now provided by our American Medical Education Foundation and the National Fund for Medical Education for emergency needs.

While our medical profession has made rapid advances in education and research and contributed significantly to the health of this country, we must lay aside our soothing preoccupation with past victories and become alerted to a peril which could result in a national disaster. Most of our medical

schools have come face to face with serious financial problems. The seriousness of this situation cannot be exaggerated, particularly as regards the notoriously insufficient incomes of many of our affiliated hospitals. Threatening financial deficits are making it exceedingly difficult for many of our medical schools to maintain satisfactory teaching standards. Competent teachers for the basic sciences are at a premium. There is a great demand today for the services of anatomists, biochemists, physiologists, pharmacologists, and pathologists in our institutions of higher learning. Many of our highly qualified academicians have been lured away to positions in industry which offer salaries two to three times greater than those provided by the medical school budget.

While a small percentage of practitioners of medicine in this country have been generous in their contributions to the American Medical Education Foundation, there has been no evidence of mass enthusiasm on a united front to support the medical schools which gave them their professional education. If all the practitioners of this country who accepted the generosity of State supported and privately endowed medical schools, which made their professional future possible, would give \$100 a year to their respective medical schools, they would make \$18,000,000 available annually, a sum which is nearly twice the amount required to pull the medical schools of this country out of the red. To the average general practitioner who in 1954 grossed \$15,800, this would represent 63/100 of one per cent of his income for the year, and this is deductible.

Tremendous advances in medicine are ahead of us in the field of research. Where there is no research there can be no progress in medicine. The outstanding doctors of today are strong, deliberative persons who are making contributions to our knowledge of medicine. They are imaginative men and women who derive theories from their observations and strive by careful experimental work to reduce them to facts. Those doctors who promptly become aware of these facts; put them to practical usage and thereby extend the boundaries of humanitarian service in the prevention and treatment of disease, likewise are important contributors to medicine.

Creativeness is the greatest thing in life. What a joy and satisfaction it is to discover some useful treatment or develop a surgical technique that changes the failures of the past into the successes of the future. And what an enviable position we hold in our profession. A wealth of fundamental facts are available to us today; scientific precepts which have laid sound foundations for investigation upon which we may build superstructures of inestimable

value in the prevention of suffering and the saving of lives.

Clinical Problems

The most important clinical problems facing American medicine today appear obvious to anyone in the practice of medicine. They embrace four areas, (1) preventive medicine, (2) mental health, (3) chronic illness, and (4) rehabilitation. The conference on Preventive Medicine in Medical Schools held in Colorado Springs in November, 1952, clearly defined the concepts of prevention and the challenges to the medical profession in carrying them out. They are quoted in part, as follows:

"Specific protection represents prevention in its strictest sense. Here, measures are taken against a particular disease or group of diseases, to intercept their causes before they involve man. Some of these measures may be applied to the environment, such as when a shield is put over the moving parts of a machine in a factory or a sewage disposal plant installed in a town. Others may be applied directly to the man himself, such as by immunization procedures."

"Early recognition and prompt treatment are the best preventive measures for disease where there is yet no known specific protection, as in cancer. They are also needed when for one reason or another, specific preventive measures were not applied, as in dental caries."

Obviously these concepts of prevention call for the fullest cooperation of public health, medicine, the nurse, the social worker and all community facilities for diagnosis and treatment; In short, comprehensive medical care. The medical profession has not yet accepted comprehensive medical care, but it is a challenge which we respect and which I believe will be met by the adoption of programs of comprehensive care at costs which people can afford to pay.

A most important area of preventive medicine is accident prevention. The Health Information Foundation reports that accidents in the United States have risen from seventh to fourth place as the cause of death since 1900. The only way to solve this problem is through education. The W. K. Kellogg Foundation seems to have clearly demonstrated this fact. They have financed programs of education which have revealed some amazing results. In Kalamazoo, for example, the rate was cut in half. Education of intensive character must be utilized to its fullest extent if accidents are to be reduced to a minimum.

There is a real awareness of the gravity of mental illness today. Judging from what we hear and read, it seems at times to constitute a total eclipse of the other problems of medicine. While groping in the

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dark for the fundamental causes of mental illness, the psychiatrists nevertheless have produced a wealth of theories and facts to account for the high incidence of this disorder. What we need now is a unity of thought and agreement on the therapeutic facts which are at our disposal and a community-wide application of them to prevent and cure mental illness.

It is encouraging to note that we are emerging from the miasma of the past and beginning to recognize the possible biologic factors in the production of mental illness. Thanks to our scientists in this field, they have adopted this new approach with a precision of action.

Chronic illness and rehabilitation go hand in hand. Some time ago the government established a commission on chronic illness. Its members have been busily at work in certain quarters with the result that they have come forth with some startling discoveries and significant facts. In a spot survey of the inhabitants of Baltimore, Maryland, their preliminary report indicates the incidence of 507 chronic conditions for each 1,000 persons. In persons age 65 and over, chronic conditions were discovered two and one-half times more frequently than in persons under 65. Much encouragement is found in the observation that a large proportion of the conditions listed in their report could have been prevented and are still reversible or capable of being brought under control. A preliminary report on a similar study in Hunterdon County, New Jersey, which has not yet been published, indicates that there will be close correlation with the findings in

Baltimore.

Rehabilitation being closely allied to prevention, the Colorado Springs Conference on Preventive Medicine gave recognition to a new specialty, rehabilitation. I quote from the Conference report as follows:

"Rehabilitation is the final weapon. Although disease has, to a greater or lesser extent handicapped the individual after it has become relatively stabilized, there are still opportunities to make use of remaining capacities. Even though changes in form and function are no longer reversible, measures may still be taken both to help the individual and to modify his environment so that he can also return as a useful member of society."

Summary

As we look to the future, I believe that these are the important problems which challenge us today:

1. Increased medical man power.
2. Recruitment and training of research personnel.
3. Adequate Medical School budgets.
4. Preventive medicine.
5. Chronic illness.
6. Mental health.
7. Rehabilitation.

While my colleagues in the medical profession may list many additional ones, I believe that most of them will fit into the categories mentioned. I hope that we are now on the road to a bold, vigorous and intelligent program of action which will solve these problems for all groups of our population, economic as well as geographic.

1313 East Ann Street

NEW HOSPITAL CARE PROGRAM

HOSPITAL CARE FOR THOSE who cannot pay has been brought closer to reality by Governor Marvin Griffin's recent approval of \$10,000 per quarter until July 1958 for use in working out a state program.

The \$10,000 will be used by the Georgia Department of Public Health to set up an administrative unit for working out the details necessary to start a hospital care program for the medically indigent.

Authorization of the program came from the 1957 General Assembly, but this is the first money approved to put the program in action. Governor Griffin has indicated that if state revenue continues at its present level, sufficient funds for full operation of the program may be available for the next fiscal year beginning in July.

A Hospital Care Council, established by the 1957 General Assembly, is considering principles and methods to be submitted to the State Board of Health for approval.

The program, according to Dr. Thomas F. Sellers, state health director, will assist counties in paying for hospital care for ill or injured persons unable to meet the cost themselves. Counties will put up matching funds on a formula being worked out by the Health Department. The program will support the provision of professional freedom of physicians and the local control of hospitals.

Taking part in the program will be a voluntary matter with each county. Certification of patients eligible under the program will be determined locally, consistent with state standards.

MESENTERIC THROMBOSIS CASE REPORT

J. BENHAM STEWART, M.D., *Macon, Georgia*

ALTHOUGH MEDICAL LITERATURE contains numerous reports of thrombosis of the mesenteric vessels, with and without recovery, instances of recovery following two operations for mesenteric thrombosis in the same person are rare. No conclusions can be drawn from one case, and because of the infrequency of repeated operation for this anomaly, there are no available series in the literature which justify conclusions. Nevertheless, the case reported here was so intensely interesting to those closely associated with it that it is recorded in the belief that it will be of general interest.

Case History

L. L. L., a white man, aged 39, was admitted to the hospital on the morning of April 14, 1952, complaining of severe abdominal pain. Four days previously he had consulted a physician because of vague, cramping pain in the abdomen, worse around the umbilicus. He had been slightly constipated. The white blood cell count and differential count were normal at that time, and because of obesity nothing could be felt in the abdomen. Two days later he was no better but continued to work until the day of hospitalization when the pain was so severe that he could not work.

There was a history of thrombophlebitis which began at least four years prior to admission with treatment elsewhere consisting of multiple vein ligations. Since that time he had had frequent bouts of phlebitis in both legs and both arms. Over the years massive edema of the left leg had developed with a huge ulcerated area on the medial surface of the left ankle. The right leg was considerably larger than normal. The use of sulfathiazole had given better results than therapy with any of the newer drugs.

The father and one brother had had some trouble with varicose veins. Otherwise, the family history was noncontributory.

On physical examination, the abdomen was obese, silent and acutely tender throughout. Both legs were chronically enlarged and edematous; there was no

A discussion of literature citing mortality rates with and without surgery, and usual mode of management.

tenderness or evidence of thrombophlebitis. Scars were present on both from previous multiple vein ligations, and there were old ulcer scars on the medial aspect of both ankles. No evidence of phlebitis was observed in the arms. The blood pressure was 140 systolic and 80 diastolic. No other findings were relevant.

The patient was given codeine and aspirin for the control of pain. The blood cell count was 5.47 million red blood cells with the hemoglobin estimation 103 per cent (15.5 Gm.) and 8,550 white blood cells with a normal differential count. Urinalysis gave negative results, and roentgen examination of the urinary tract gave no evidence of abnormality. Shortly after admission, the patient became comfortable and had a good night.

Early the next morning severe abdominal pain recurred. An enema produced some feces and much flatus but failed to relieve the pain. The blood sugar determination was 137 mg. per hundred cubic centimeters, the icterus index six units and the serum amylase 52 units. Urobilinogen was positive in the urine in a dilution of 1:40. That night the patient seemed to be much worse. The white blood cell count was 18,500 with 88 per cent polymorphonuclear cells, and the abdomen became rigid. It was decided that abdominal exploration was necessary. The patient then began to vomit dark blood, and a diagnosis of mesenteric thrombosis was made. In the operating room before the anesthetic was administered the patient vomited such a large amount of bloody fluid that a blood transfusion was deemed necessary before surgery was undertaken. He received two pints of blood then and three pints during the operation.

At operation, through a right rectus incision the peritoneum was opened. About four inches below the ligament of Treitz a sharply demarcated line was encountered where the intestine became gangrenous.

To Dr. Alton Ochsner of New Orleans I wish to express my appreciation for advice and suggestions in handling this case. Also, I am indebted to Dr. Thomas Harrold, Jr., Dr. W. Derrel Hazlehurst and Dr. Henry H. Tift of Macon for their active consultation and support.

MESENTERIC THROMBOSIS / Stewart

Beyond this line a segment about four feet in length, of doubtful character and in part gangrenous, was excised, and the mesentery was ligated. An end to end anastomosis was formed, and in routine fashion the rent in the mesentery was repaired. Since most of the omentum was becoming discolored because of thrombosis in the omental vessels, it was resected above the devitalized portion. The wound was closed in layers, and through and through silver wire sutures were placed. The immediate postoperative condition of the patient was satisfactory.

Penicillin and streptomycin were administered postoperatively, and also Depo-Heparin since it was necessary to employ Wangensteen suction. The patient made excellent progress. On the fourth postoperative day, he felt well and walked out in the hall. As he returned to bed, he was seized with severe abdominal pain. An enema produced old blood and much flatus, but gave no relief. Even opiates did not relieve the pain completely. The administration of ACTH was begun. Soon after Wangensteen suction was started, dark blood appeared. He was given two pints of blood before being taken to the operating room where a third pint was given.

When the original incision was reopened on April 21, the intestinal anastomosis was in good condition so far as leakage was concerned. The proximal portion of the intestine was healthy, but distal to the suture line a segment of intestine about 18 inches in length was black. About one inch of the intact intestine proximal to the anastomosis was sacrificed, and a segment of the intestine was resected to a point well below the devitalized portion. With it was removed a wedge of the mesentery, taken out in an attempt to get as deep into the mesentery as possible and yet avoid the great vessels. An end to end anastomosis was formed. The mesentery then was sutured together. No other evidence of pathologic change was observed in the abdomen. The omentum which was left at the first operation was in good condition. The wound was closed with interrupted chromic catgut and with through and through silver wire sutures. The skin was closed between the silver wire sutures with interrupted black silk sutures. A sterile dressing was applied. The patient's immediate postoperative condition was satisfactory.

Following this second operation, treatment with streptomycin, penicillin, ACTH, and Depo-Heparin was continued. The dosage of Depo-Heparin was regulated according to the clotting time, which was carefully followed. As soon as oral medication could be given, a change was made to Dicumarol with prothrombin activity used to regulate the dosage. After each operation the patient was ambulatory within 24 hours. Fluid balance was carefully maintained, and

despite the danger, most of the fluid had to be given by vein. Proctoclysis was used as much as possible. Subcutaneous injections were impractical because of chronic edema. Vitamins were administered with the fluids.

Recovery was uneventful. The patient was discharged from the hospital on the thirteenth postoperative day.

Five days after leaving the hospital the patient was seen in his home. He was rolling about on the bed in agony, suffering from recurrent paroxysms of abdominal pain. The temperature was normal, and the pulse rate was 100. The abdomen was tense, but not rigid. He was hospitalized immediately, and treatment with ACTH was begun again. At the time of discharge from the hospital a few days earlier, he had been receiving a maintenance dose of Dicumarol, and the prothrombin activity was satisfactory. Now the white blood cell count was 13,400, and there was a pronounced shift to the left. He was heavily sedated. By morning, he was symptom-free and has remained so.

Summary

A case is reported in which the patient was twice successfully subjected to operation for mesenteric thrombosis, the second operation following the first by five days.

With regard to the value of anticoagulants or ACTH in the treatment of a patient with thrombosis of the mesenteric vessels, it would seem logical to take advantage of every aid in dealing with so grave a problem.

210 Doctors' Building

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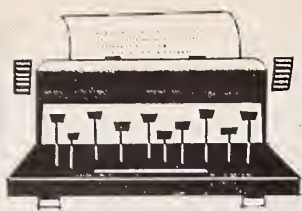
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editorials

ON HAVING CHILDREN

PHILOSOPHY AND PSYCHIATRY (Freudian at least) do not agree on which of man's many drives is the most forceful. To engage in such mental gymnastics is unnecessary if one accepts the obvious—man's urge for reproduction is relentless, ever present, and the mainspring of human motivation. Although the world's population is increasing in what has been termed "an alarming rate," such figures are of little comfort to the anxious barren couple. About ten per cent of American marriages are barren. The physician is challenged by these three million involuntarily childless couples who come to him for help. How can they best be helped?

In the absence of specific therapy, confusion, false impressions, superstitions enter a picture which is a scientific enigma. By its very nature research into the problems of infertility is slow. But like other seemingly insurmountable scientific problems, the answers will ultimately be forthcoming. In the meantime an ostrich-like attitude serves no useful purpose. One of the reasons for the lack of enthusiasm is perhaps due to the failures reported by physicians who are not well trained in the principles of sterility study or in the performance and interpretation of necessary tests.

The causes of infertility are multiple and a complete study of both husband and wife is essential. In addition to a detailed history and physical examination of both parties as well as blood Wassermann test, complete blood counts, urinalyses and basal metabolism test, the wife will require: tubal insufflation, endometrial biopsy, intracervical post-coital examination as well as an incompatibility test with cervical mucus and semen. A cervical smear, gram stain, vaginal hanging drop and stain smear as well as studies related to ovulation timing such as endometrial biopsy and basal body temperature are essential. The husband's examination must include

studies of prostatic secretion, fluid specimen and stained smear as well as a complete semen analysis. The performance of some of these tests will require special training. More important is the training necessary to properly interpret the results of this battery of examinations. The application of correct therapy will require special knowledge on the part of the physician.

From a review of the literature one would suspect that hormonal therapy is the treatment of choice whereas eminent authorities on the subject categorically state, "There is very little benefit from hormone therapy in infertility." Testosterone actually causes a decrease in spermatogenesis except in isolated cases. Although this well established physiological principle has been known for many years, testosterone is the most abused drug in the treatment of male infertility. The purpose therefore of this pithy report is to once again decry the indiscriminate use of drug therapy in the treatment of the anxious infertile couple. In proper hands and with selected cases success is certainly possible in the treatment of some of these three million desperate marriages.^{1,2}

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THE MANAGEMENT OF ESOPHAGEAL EMERGENCIES

THE ESOPHAGUS, from the surgical perspective, no longer represents the much to be feared and fragile organ it once did. It has been approached surgically in all of its respective locations with relative impunity. However, if those emergency conditions which can be associated with it are not recognized and promptly treated, dire results can transpire. These emergencies can be considered under the heading of atresia, perforation, insidious and/or massive bleeding, and obstruction. All of these complications can be diagnosed early and in the main successfully treated.

The most common type of atresia involves that in which the distal limb of the esophagus is attached to the trachea or one of the main stem bronchi, with the proximal limb a dilated blind stump. This is known in most texts as the No. 3 type of abnormality and easily accounts for well over 90 per cent of the atresia which is seen. The diagnosis of this entity is usually made by the intelligent and observant nurse, who discovers early in the child's first few hours of life there is much regurgitation, and that when a

small feeding or suction catheter is introduced it goes in eight to 10 cms. and then coils and meets an obstruction. A small amount of lipiodol admirably shows this blind pouch. The abdomen is frequently protuberant and the film shows stomach and bowel to be distended with air. The explanation for this is the fistulous connection between the endobronchial tree and the lower esophageal limb. This complication is readily managed by a right thoracotomy, preferably extra pleural, with identification and closure of the fistulous connection and a two layer fine silk suture anastomosis of the blind stump to the distal limb of the esophagus. It is necessary to free up the proximal stump for at least two inches or more in order to accomplish the anastomosis free of tension. The circulation to the lower limb is less adequate and it must be handled very painstakingly insofar as dissection is concerned. The fistula in the endobronchial tree, whether this be the trachea or the right main stem bronchus, must be closed meticulously with interrupted fine silk sutures. This type of approach to the problem in careful hands should be met with success in at least 40 to 50 per cent of the cases. A gastrostomy may well be done in the immediate postoperative period to afford feeding for the infant, if in the opinion of the surgeon he will not be able to feed the patient by mouth. It has been my experience on several occasions that feeding can be instigated early in the postoperative course and this particular portion of the procedure can be obviated.

Perforation of the esophagus may be spontaneous or traumatic. Spontaneous perforation of the esophagus may well mimic a perforated peptic ulcer, coronary thrombosis, acute pancreatitis, and acute cholecystitis, or any other perforated upper abdominal viscus. It occurs following a vigorous bout of vomiting. The rent is usually of a longitudinal type and is in the lower third of the esophagus. There may be a right or left hydropneumothorax, as well as mediastinal emphysema, with this extending into the neck. However, the diagnosis must be suspected in all situations associated with the acute onset of epigastric pain and rigidity of the abdomen which occurs subsequent to vomiting episodes. Films of the chest should be taken and the patient's history carefully evaluated. If the diagnosis is made early enough, thoracotomy with suture of the laceration with fine silk and drainage of the respective hemithorax into which the perforation has occurred is the treatment of choice. If the perforation is caused by manipulation, such as in esophagoscopy with bougies, certainly a very careful evaluation of the patient's postoperative progress must be made and urgent mediastinotomy done with repair of the laceration and drainage of the site of perforation.

It has been the author's experience that even after perforation of the esophagus because of a carcinoma it has been possible to do a primary esophagectomy and esophagogastrostomy with success. This particular perforation described was not diagnosed until some 24 hours after esophagoscopy and biopsy had been performed. Similar cases have been reported at the Mayo Clinic when perforation occurred at the time of esophagoscopy and it was possible to do a primary resection of the carcinoma and anastomosis with success.

Insofar as bleeding is concerned, if this is from a hiatus hernia or esophageal varices, surgery again may be met with excellent results. The hernia and/or varices can be repaired either from the abdominal or thoracic approach and this will afford the patient relief of symptoms. If the patient has large varices and is bleeding massively from these, they should be ligated. Often immediate control of the bleeding can be had by the use of the Blakemore Sengstaken tube with its triple lumen and two balloons. The abdominal route may be used and this is recommended by C. Stuart Welch.¹ Here the esophagus is exposed in its lower aspect, after cutting the triangular ligament of the liver, and the offending varix is identified and sutured in an over and over fashion. The same technique of over sewing the varix can be used through the thoracic approach by Warren and Linton,² and both groups of authors have reported successful cases managed using these methods.

When obstruction is the problem, certainly very careful esophagoscopy should be performed. If there is a stricture that can be dilated with appropriate bougies this can be done. If this is unsuccessful, then a pyloroplasty type procedure can be performed, and this might best be the Heller type of pyloromyotomy. Dr. R. Sweet of Boston prefers the Heineke-Mickulicz type operation for this difficulty of stricture of the lower esophagus. Obviously, if the lesion is found to be a carcinoma and resection can be performed, this is done. In extensive lye strictures of the esophagus and occasionally with cancerous lesions, various authors have reported success in using colon and jejunal transplants with bypass of the obstructing esophageal segment.

With the availability of excellent anesthesia, blood replacement, the age of numerous effective antibiotics, and in the hands of careful and capable surgeons all of these esophageal complications can be managed in a most acceptable fashion. This particular organ need no longer doom its possessor to a life of handicap or death when its physiology and/or anatomy goes awry.

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A HALT TO GEORGIA'S MARRIAGE MILLS?

A BILL TO REQUIRE a three-day waiting period before marriage will probably be introduced in the January 1958 session of the Georgia General Assembly.

Indications are that the measure will be sponsored by the Governor. A similar bill introduced in the 1956 session by Rep. Albert Campbell of Walker County failed to pass and was not supported by the Governor.

The MAG policy in this matter is clear. The May 1956 Session of the House of Delegates declared, "BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia urge the Georgia General Assembly to amend the present marriage law to require that no marriage license shall be issued earlier than three days following the date of the application therefor." This recommendation,

sponsored by the Polk County Medical Society, was adopted unanimously by the House of Delegates.

At the request of the Governor, the State Department of Public Health recently made a study of marriages in Georgia and arrived at the following interesting statistics:

For the year 1956, brides in 37.2 per cent of all the marriages in the state were non-residents.

Of these non-resident brides, 49.6 per cent were from Florida; 24.3 per cent from Tennessee; 10.9 per cent from Alabama; 2.1 per cent from North and South Carolina; and 10.9 per cent from other states.

Florida and Tennessee both have three-day waiting periods.

To pinpoint the marriage mill counties, the Health Department charts showed that in Dade, Walker, Catoosa, Rabun, Echols, Charlton, Camden, and Brantley Counties, non-residents were brides in 75 to 100 per cent of all marriages; in Murray, Fannin, Towns, Quitman, Clay, Seminole, Decatur, Thomas, Lowndes and Hart Counties, 50 to 74 per cent of all marriages involved non-resident brides.

These charts and figures were made public at the October 17 meeting of the State Board of Health.

Appointments and Promotions in Emory Medical School

EXPERTS IN SCIENCE from other countries are among professors recently added to the faculty of medical school and related areas at Emory University.

Dr. Geoffrey Bourne, appointed last spring, assumed his duties this month as chairman of the department of anatomy. Dr. Bourne is an expert on nutrition and ageing. A native of Australia, he is a former professor at the London Hospital Medical College.

Newly appointed are Dr. David Brandes, formerly with the Argentina Atomic Energy Authority; Dr. Abdel F. Baradi, lecturer at Abbassiah Medical College, Cairo, Egypt; and Dr. W. C. Osman-Hill, research scientist at the London Zoological Gardens. Dr. Osman-Hill is the author of two volumes on monkeys and is a world authority on the subject.

German-born Dr. Gherhard Brecher has been named professor of physiology. He has taught at American and European universities, and served with an UNRRA team.

A new department of neurology is being organized with Dr. Herbert R. Karp as the first full-time teacher assigned to this area. Dr. Karp is a native of Atlanta, and a graduate of Emory. He has been

associated with the Communicable Disease Center in Atlanta.

Other appointments in medicine and related sciences are: Dr. Elbert Tuttle, assistant professor of medicine; Dr. Huddie Cheney, Jr., instructor in medicine; Dr. Garland D. Perdue and Dr. Harrison L. Rogers, Jr., instructors in surgery; Dr. Richard K. Davenport and Emil W. Menzel, Jr., research associates in Yerkes Laboratories of Primate Biology, Orange Park, Fla. In addition 30 voluntary part-time) techers have been named to the medical faculty.

Fifty-nine promotions in the medical school include 40 part-time and 19 full-time faculty members. Promoted from associate professor to professor are: Dr. Benjamin R. Gendel, Dr. Ted Leigh, Dr. R. Bruce Logue, and Dr. J. Elliott Scarborough. Promoted from assistant professor to associate professor are: Dr. William H. Galvin, Dr. Charles M. Huguley, Jr., Dr. Osler A. Abbott. Dr. Robert L. Brown, Dr. Frederick W. Cooper, Dr. Edgar Fincher, Dr. J. Splading Schroder, Dr. William H. Kiser, Jr., and Dr. Joseph H. Patterson.

Electrolytes in Heart Failure

ARTHUR J. MERRILL, M.D., *Atlanta, Ga.*

OUR PRESENT concept of congestive heart failure is that the cardiac output is inadequate for the demands of the body. This causes an inadequate arterial blood volume. The resulting stimulus to the adrenal cortex with increased aldosterone production causes sodium retention, increased antidiuretic hormone causes water retention, and a fall in kidney blood flow and filtration rate cause both salt and water retention. The latter makes exercise particularly important in cardiac subjects whose hearts cannot respond to the increased demand. It is likely that some potassium is lost and also some cell protein.

In management of the salt and water retention one can: (1) Increase cardiac output with digitalis or temporarily with aminophyllin, or by correcting mechanical defects surgically, (2) Reduce tissue demands by limiting activity, repairing A-V fistulas, removing toxic goiters, correcting anemia, and giving vitamin B complex if the patient is deficient, (3) Limit sodium intake, and (4) Increase sodium output by the use of diuretics, the most useful of which decrease renal tubular reabsorption of salt.

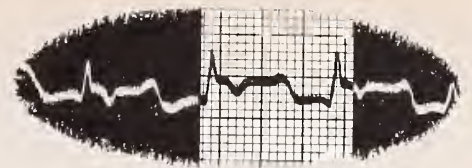
In the treatment of heart failure certain electrolyte imbalances may be produced. Hyponatremia, or the low salt syndrome, occurs only in very severe heart failure or in heart failure in a patient with poor renal function. It produces drowsiness, weakness, nausea and vomiting, edema, coma, and refractoriness to mercurial diuretics.

In a few cases true salt depletion is found from rigid salt restriction in association with excessive mercurial diuretic administration. Usually vomiting has contributed to the picture. Many more cases accompany severe heart failure with a powerful salt and water retaining stimulus when only salt is restricted. In such instances water *excess* rather than sodium *depletion* causes the low blood sodium. With true salt depletion administration of hypertonic or five per cent NaCl often produces a dramatic improvement and the patient seems better only to die

in a few months of intractable failure. The sodium dilution syndrome is usually made worse by five per cent NaCl and pulmonary edema may ensue. Temporary improvement may be achieved by giving aminophyllin 60-90 minutes after the mercurial or by producing a water diuresis with the administration of alcohol.

When patients become refractory to mercurial diuretics, particularly when NH_4Cl has not been given, hypochloremic alkalosis with a low blood Cl^- and a high CO_2 combining power must be considered. Since Na^+ and Cl^- are not present in equal amounts in the extracellular fluid, the loss of equal amounts of both as a result of mercurial diuretics will leave an excess of sodium. As a result of the alkalosis, renal function is diminished and also potassium will be lost. This may be corrected by giving NH_4Cl or by using diamox or a sodium-adsorbing resin. The latter two measures will aggravate the potassium deficiency and potassium must be added. Even when ammonium chloride is given routinely for a few days before mercurial injections, if Cl^- diuresis exceeds the replacement of Cl^- , if NH_4Cl fails to be absorbed or is vomited up, hypochloremic alkalosis can occur.

When marked drowsiness or coma develops in congestive heart failure, hyperchloremic acidosis or NH_4Cl poisoning must be considered. It is often misdiagnosed as terminal renal disease, diabetic acidosis, cerebrovascular accident, and dehydration. This condition is usually produced by the administration of NH_4Cl to a patient with impaired renal function, though occasionally prolonged administration of NH_4Cl can cause it in patients with good kidneys. Diamox may produce this state temporarily through loss of sodium, but increased ammonia production by the kidneys soon remedies this. Resins which exchange H^+ ions for Na^+ ions may also produce the same sort of Na^+ depletion. Renal failure, particularly the type brought about by pyelonephritis, may cause it. The victim of heart



heart page

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

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HEART PAGE / Merrill

failure exhibits added stupor, hyperpnea, low CO_2 combining power, and some azotemia. Cessation of the NH_4Cl will correct the imbalance in moderate cases but in severe cases 1500-3000 cc. of alkaline Na- salts I.V. are necessary to save the patient's life.

Resins intended to remove Na^+ also remove potassium and calcium unless these are added to the resin, and deficiencies must be watched for. Hyperchloremic acidosis caused by the H^+ cycle resin is not usually severe when the kidneys are normal because the kidney reduces the acidosis by increasing the production of ammonia to spare

sodium.

Carbonic anhydrase inhibitors cause hyperchloremic acidosis by elimination of sodium but this lasts only two or three days until increased production of ammonia clears it up.

Potassium loss in the urine is increased temporarily with administration of mercurial diuretics, NH_4Cl , diamox, and cation exchange resins. Depletion of K^+ causes a reversible lesion in the renal tubules which brings about further loss of K^+ and also produces a lesion in the myocardium which is capable of initiating heart failure even in the normal heart. Furthermore, potassium depletion enhances digitalis intoxication. Its importance cannot be over-emphasized and its treatment must be prompt.

The Trend Toward Socialized Medicine

W. BRUCE SCHAEFER, *Toccoa, Ga.*



president's letter

A FEW NIGHTS AGO I was asked if I believed in socialized medicine. The answer is definitely NO! But the trend is definitely YES. I feel so often like the old story of the mighty oak and the small sapling that were in a terrific thunder storm. The mighty oak would not give an inch and eventually the storm broke its back and it crashed to the ground. The young sapling bent its back into the wind and rode out the storm, only a little worse for wear. I feel so often that we doctors are like the mighty oak; we don't want socialized medicine, we say, but we won't give an inch to prevent it.

Several years ago the Wagner-Murphy-Dingle bill was defeated by the doctors of the United States on the doctor-patient relationship, and we should have learned to give, to preserve this relationship. But have we? The trend is now more and more towards socialized medicine. We have Medicare. We now have hospital and medical care for the welfare and aged paid for by the government. We have a bill which will be entered in the next congress to include in government medical care all members of the social security group in the United States. The veterans today are asking for a hundred thousand more beds to take care of veterans of world wars, most of which are non-service connected disabilities.

Labor groups say that they are through with private practice of medicine. They are going into

contracts with contract doctors on salary and they are going to render free medical care and hospital care to their patients on a socialistic form of medicine. Would all of this have happened had we maintained our doctor-patient relationship? We have let one group of doctors make contracts with industry which, in turn, has forced the employees to take these doctors whether they wanted them or not. We have thus destroyed this doctor-patient relationship in the group of wage earners which has allowed the union to reach the position that they are now in, in contract practice.

We have formed clinics which have discouraged the doctor-patient relationship in order to better distribute the work among our clinic group. We have rotating night calls, and other doctors refusing to take night calls altogether further destroying the doctor-patient relationship. What is the answer? These are problems that we all are facing each day and problems that will ultimately change the face of medicine. I can still remember when there was a great howl over the country about free education for everyone but it is well accepted today, except that the teachers are eternally and forever lobbying trying to get a decent salary upon which to live and get security. Are we to join this group of professional people? That is the question.

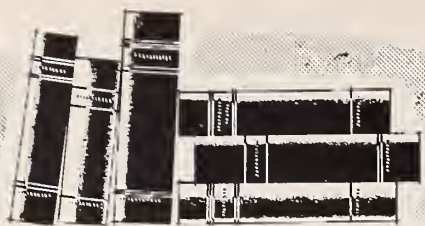
W. B. Schaefer, President

DIABETES AND BASIC METABOLIC PROBLEMS

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physician's bookshelf

BOOKS RECEIVED

Schamroth, L., M.D., *AN INTRODUCTION TO ELECTROCARDIOGRAPHY*, Charles C. Thomas, Springfield, Illinois, 1957, 58 pp., \$2.50.

Marshall, Mary Louise, *THE PHYSICIAN'S LIBRARY*, Charles C. Thomas, Springfield, Illinois, 1957, 82 pp., \$3.00.

Tonkin, Richard D., M.D., *THE STORY OF PEPTIC ULCER*, W. B. Saunders Company, Philadelphia, 1957, 71 pp., \$2.25.

Dripps, Robert D., M.D.; Eckenhoff, James E., M.D.; Vandam, Leroy D., M.D., *INTRODUCTION TO ANESTHESIA*, W. B. Saunders Company, Philadelphia, 1957, 266 pp., \$4.75.

Roberts, Sam E., M.D., *EAR, NOSE AND THROAT DYSFUNCTIONS*, Charles C. Thomas, Springfield, Illinois, 305 pp., \$8.50.

Wenger, H. Leslie, *THE SPINE JACK OPERATION*, New York, 1957, 86 pp.

REVIEWS

Schwartz, Tulipan, and Birmingham, *OCCUPATIONAL DISEASES OF THE SKIN*, (Third Edition), Lea and Febiger, 1957, Philadelphia, Pa., \$18.00.

This, the third edition of Schwartz' "Occupational Diseases of the Skin," although much improved, remains the same classic volume as his first edition, and, as such, contains a wealth of authoritative information not available elsewhere. In this revised edition one finds a new chapter outlining methods of investigation of industrial skin eruptions, an instruction which has always been needed.

The entirely new chapter on "Skin Hazards and Radiation in Atomic Industry" by Dr. W. D. Norwood is alone worth the cost of the book. I know of no other source where so much essential information can be found. This chapter should be a "must" for all medical students. Also added, has been a chapter on "Occupational Marks" by Dr. Ronchese, an authority in this field; and there has been much new information on the skin hazards in industry added to Chapter 47.

This volume is a necessity for the practicing dermatologist and the industrial physician, and any medical insurance examiner would profit by its use. In addition, it can be highly recommended for the desk of the general practitioner.

Herbert S. Alden, M.D.

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

Mulholland, John H., M.D.; Ellison, Edwin H., M.D.; and Friesen, Stanley R., M.D., *CURRENT SURGICAL MANAGEMENT*, W. B. Saunders Company, Philadelphia, 1957, 494 pp., \$10.00.

This is an unusual volume of surgical procedures and management. Seventy-six surgeons, both young and old, and from various parts of the country have written their opinions.

Surely, everyone can find agreement with their own ideas or new ideas. There are no illustrations, and no surgical technique is described. However, the text is so tabulated or paragraphed as to make for easy reading and comparisons.

The print and format are of the usual Saunders quality.

It is a book to be studied in time of doubt and should help one find a satisfactory solution.

Floyd W. McRae, M.D.

Robbins, Stanley L., M.D., *TEXTBOOK OF PATHOLOGY*, W. B. Saunders Company, Philadelphia and London, 1957, 1350 pp.

This book presents many important subjects which are neglected in most of the older standard texts of pathology. These subjects are of paramount importance to the student of today if he is to understand the fundamentals involved. Dr. Robbins' short comments on "exfoliative cytology" are very good. The chapter on "Disturbances of Body Fluids" is timely and well written. A separate chapter on "Collagen Diseases" is desirable, but more space might be devoted to this interesting and complex group of diseases. The chapter on "Diseases of Infancy and Childhood" is excellent and has been almost uniformly neglected in the past.

The author, in the first XIV chapters, develops the fundamentals of pathology in a very orderly fashion, but chapters XV through XXXII are devoted to diseases of specific organs or organ systems. This approach, in my opinion, leads the student to think of a disease in relation to an organ rather than as an entity involving all organs and organ systems.

The outlines at the beginning of each chapter are excellent and should be helpful to the student.

Most of the photomicrographs are of top quality, but some are poor. The photographs of gross material, in many instances, leave much to be desired.

The references at the end of each chapter are adequate, but not too numerous and are up to date.

This text can be recommended to students, primarily, because of its special chapters which bring the subject matter up to date.

Lee Howard, Jr., M.D.

Epstein, Ervin, M.D., *SKIN SURGERY*, Lea and Febiger, Philadelphia, 1956, 223 pp., \$7.50.

This small handy manual is a compilation of several articles on surgical methods at some time used by dermatologists in their office practices.

Because of its somewhat controversial title, and maybe because of its sometimes controversial content, the author feels impelled to introduce the volume with the chapter, "Why Dermatologic Surgery?". Since the word "surgery" has, in the public eye and occasionally among medical men, brought to mind a picture of hospitals,

HEALTH SERVICES IN GEORGIA

FOR A COST of a little over \$5.00 per person, Georgians during the fiscal year 1956-57 received the benefits of health department services, hospital construction, operation of Battey State Hospital, and polio vaccine.

Total state and federal money spent for these benefits was \$18,484,752.

This and other information reviewing past accomplishments and outlining new programs was presented October 17 to the State Board of Health by Dr. Thomas F. Sellers, director of the Georgia Department of Public Health.

Dr. Sellers reported that progress is being made in setting up a model screening center for the mentally disturbed at the Eugene Talmadge Hospital at Augusta, but that recruiting a staff is a big problem.

New and proposed hospital construction was outlined to the Board. There have been 56 new hospitals since the Hill Burton Act of 1946. Recent new hospitals have been built in Cumming, Homer-ville and Colquitt; new construction is going on at Monroe, Warm Springs and Dallas; new projects are approved for Lawrenceville and Jesup; and additions are being built at LaGrange, Columbus, Brunswick, Albany, Gainesville, Franklin, Duluth, Thomasville, Marietta, and Athens.

The Board was informed that a plentiful supply of flu vaccine is expected in Georgia in the next few weeks and that 472,934 persons had received three injections of polio vaccine since the polio program began two years ago.

The Board adopted rules and regulations for control of water purification plants and sewage treatment plants. All regulations are in keeping with the principle that the user of water from a stream must use only a reasonable amount and must return used water to the stream in good condition. The regulations give details for submitting plans and specifications for proposed water or sewage plants, and set up requirements for regular reports to the State Health Department concerning physical, chemical and bacteriological quality of water. One regulation permits owners of water purification plants, sewage plants, and industrial waste treatment plants to apply to the State Health Department for a certificate of approval for stream use.

The Board also heard a report on the progress of a program on hospital care for those unable to pay, as set up by the 1957 General Assembly when a Hospital Care Council was created to advise and assist the Georgia Department of Public Health in setting up such a program. The program will encourage local responsibility and will support the preservation of the professional freedom of physicians and the local control of hospitals. Counties wishing to receive funds must put up matching funds on a formula to be developed.

The Board voted to recommend to the foremen of county grand juries that a dentist be appointed to the Board of Health where possible within the framework of present laws.

physician's bookshelf

CONTINUED

operating rooms, gowns, masks, and gloves, with life and death hanging in the balance, such an explanatory chapter is necessary.

This book deals with the small techniques which must necessarily be an integral part of every dermatologic practice. In this, it fills a void which all dermatologists will much appreciate. The eighty pages, from 53 to 133, describe surgical techniques and surgical procedures which could well be left to major surgical textbooks, since they describe operative work which, however informative, is not within the province of the dermatologist.

The remaining one hundred and fifty pages deal excellently with techniques and procedures which not only every dermatologist should know well, but which the general surgeon and the general practitioner should be familiar.

This book should be a boon to the dermatologist and should be on the useful side of his library shelf; however, it also should be in the hands of the general sur-

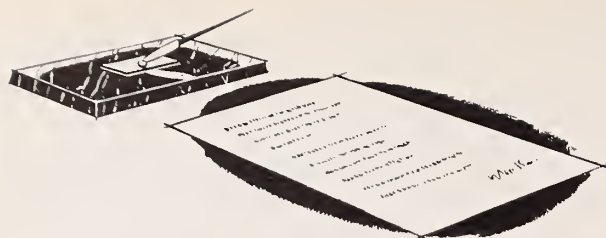
geon, and its contents should be least as familiar to the general practitioner. For these medical men I can heartily recommend it.

Herbert S. Alden, M.D.

Adler, Francis Heed, M.D., GIFFORD'S TEXTBOOK OF OPHTHALMOLOGY, W. B. Saunders Company, Philadelphia, 1957, 499 pp. \$8.00.

This latest revision of a fundamental text aimed at supplying practical information about diseases and injuries of the eyes to the medical student and general practitioner is one that will be used in everyday practice. Avoiding the rarer conditions that would interest the specialist, it covers well the average emergencies and care in minute detail and is indexed to general situations by chapter for quick thorough review by the practitioner. Emphasis on changing medical scenes of therapy from certain diseases fast disappearing into those channels of present problems, including viral and degenerative diseases, upholds a newer medical trend. As a reference book for students and general practitioners it serves an excellent purpose in presenting everything they are likely to desire or need to know about the eye.

W. GRANVILLE TABB, JR., M.D.



abstracts by georgia authors

Kornfeld, Walter, Department of Physiology, School of Veterinary Medicine, University of Georgia, Athens, Ga., "Gonadal Effects Upon the Growth of Pituitary, Adrenals, Thyroids, Oviduct, and Comb of Immature Fowl," *Anat. Record* (July) 1957.

Gland and tissue growth has been studied in intact pullets and birds ovariectomized during the third week after hatch. Measurements were made at the age of 17, 30, 45, 60, 75, 85, and 100 days and the influence of seasons upon growth was also determined for the oldest group.

Absence of the ovary did not seem to affect body weight or the growth of comb and thyroids. It had no effect upon the frequency with which right gonads of the testicular type were observed.

Ovariectomy had a significant effect upon rudiment, oviduct, and pituitary growth.

The findings were related to gonadal function. It appears that the ovary of fowl secretes estrogen far earlier than is generally believed.

Growth was linear for thyroids, oviduct, and comb regardless of treatments. The ovary of pullets and the right gonad of poulards also grew linearly. The rudimentary gonad of pullets failed to grow and their pituitary weight reached a peak at 75 days after a period of linear growth. Pituitary growth in poulards was linear throughout.

Thyroid weight was very significantly depressed in summer regardless of treatment and adrenal weights showed a highly significant interaction between ovariectomy and season. No significant seasonal effects were observed upon body weight and the growth of gonads, pituitary, comb, and oviduct.

Lewis, John R., 478 Peachtree St., N.E., Atlanta, Ga., "The Treatment of Hemangiomas," *Plas. & Reconstruct. Surg.* 19:201-212 (March) 1957.

Hemangiomas have been treated in the past by surgery and by x-ray and radium, as well as by various other methods such as the use of dry ice and, to a limited degree, by injection of

sclerosing agents. This paper is a plea for the use of sclerosing solutions in preference to the use of more radical surgical treatment. Surgery, in many cases, must leave considerable scarring and deformity; and x-ray and radium, to accomplish a good result, nearly always leave scarring and may leave underlying deformity of the bone and soft tissue due to underdevelopment when the treatment is carried out at an early age. The present paper deals with the use of a compound sclerosing solution consisting of five per cent sodium morrhuate, two per cent procaine solution, and hyaluronidase. The use of the sodium morrhuate-procaine-hyaluronidase mixture is very satisfactory in that the solution diffuses very well through the hemangioma and sloughing is quite unusual. The ultimate result of treatment has been very satisfactory and secondary surgery has been necessary only for very rare cases and in those tumors which are extremely large. In those cases in which surgery is necessary following the conservative treatment by injection of sclerosing solution, the surgery is a much simpler procedure than would have been necessary had the use of the sclerosing solution not preceded it. The results are good and with minimal scarring photographs demonstrated results of treatment in various size lesions and lesions in varied areas of the body.

Rosenberg, Alfred P., B.S., and Greenblatt, Robert B., M.D., Medical College of Georgia, Augusta, Ga., "A Simplified Introduction to Steroid Chemistry for the Clinician," *J. Am. Geriatrics Society* 5:486-496 (May) 1957.

The past decade has been witness to the change in the role of the steroid hormones from that of research oddities to that of major therapeutic tools. Though much has been written for the clinician concerning the therapeutic application of these hormones, little digestible information has been provided him with regard to the chemistry of this important family of physiologic compounds. This paper presents as simply as possible some of the basic principles of steroid nomenclature, chemistry, and metabolism. The steroids

chiefly discussed are the estrogens, the androgens, the corticoids, and the progestational compounds and their derivatives.

Fleming, J. W. and Bloom, W. L., Piedmont Hospital, Atlanta, Georgia, and the Medical Research Laboratory, V. A. Hospital, Chamblee, Ga., "Further Observations on the Hemodynamic Effect of Plasma Volume Expansion by Dextran" *J. Clin. Invest.* 36:1233-1238 (August) 1957.

Following intravenous administration of 1,000 to 1,500 ml. of six per cent dextran to normal individuals, there is prolonged plasma volume expansion. This increased plasma volume alters normal pressure-volume relationships in both the pulmonary and systemic vascular circuits, causing relatively greater increases in pressure in the pulmonary system. In some patients, accommodation to this plasma volume expansion might occur by generalized capillary and venous dilation, allowing the systemic venous and right atrial pressure to return toward normal levels. Cardiac output is usually increased, but this increase is not consistently associated with any measured pressure change in the venous or pulmonary system or the degree of plasma volume expansion. In contrast, a few patients with an expanded plasma volume may fail to increase cardiac output in spite of high right atrial and pulmonary arterial pressures.

Williams, George A., M.D., and Richardson, A. Cullen, M.D., Emory University School of Medicine, Emory University, Ga., "Conization Biopsy of the Cervix," *Obst. & Gynec.* 10:60-62 (July) 1957.

A heavy premium is placed on early diagnosis of carcinoma of the cervix and this must be done by screening technique, such as cytological smears, and biopsy. The final diagnosis frequently rests upon conization biopsy of the cervix which should include the entire squamocolumnar junction, some of the surrounding portio, and as much of the endocervix as possible. This tissue should be removed with as little trauma as possible.

A seemingly simple procedure, the techniques employed are not uniformly successful, and the small traumatized bits of tissue are frequently unsatisfactory. The special instruments devised for biopsy of the squamocolumnar junction, including one devised by the senior author, are not suitable for the lacerated, averted, eroded, and otherwise distorted cervix likely to present itself a study of suspected malignancy. Technique and common use with traction on the anterior lip of the cervix is unsatisfactory because it distorts the cervix by elongation of the anterior lip and does not steady the posterior lip.

The authors have devised a method, central traction, using a small Lewis tonsil screw or for smaller cervixes, a modified Newman tenaculum. The cervix is steadied uniformly and shortened uniformly. The cone is removed by circular strokes of the knife and usually the entire depth of the endocervix can be secured for study virtually untraumatized.

Greenblatt, Robert B., M.D.; Manautou, Jorge Martinez, M.D., with collaboration of Tigerman, N. R., B.S.; Rogers, R. L., Jr., M.D.; and Sheffield, F. H., M.D.; Medical College of Georgia, Augusta, Ga., "A Simplified Staining Technique for the Study of Chromosomal Sex in Oral Mucosal and Peripheral Blood Smears," *Am. J. Obst. & Gynec.* 74:629-634 (Sept.) 1957.

A new and simplified technique is described employing pinacyanole as the stain. The method proved to be moderately easy and quick with a high percentage of accuracy.

Oral mucosal and blood smears were studied in 90 sexually normal patients of both sexes, and in 12 patients with sexual abnormalities. In the normal cases the diagnosis was correct in 100 per cent of the oral mucosal smears and 97.14 per cent of the blood smears. In the abnormal group, there were three cases of gonadal dysgenesis in which the diagnosis was different in the blood and mucosal smears.

Thirty patients with known endocrinopathies and other medical disorders were tested and the diagnosis was correct in 100 per cent of the cases. In our overall studies to date five cases

have been encountered in which there was a discrepancy between mucosal and blood smears.

A recent article by Ashley helped to explain the variance in the results obtained in our mucosal and blood smear study of sex chromatin patterns. It appears that in blood smears, the satellite body of Davidson and Smith is not identical with the heterochromatin mass and must be regarded as a sex characteristic rather than the sex chromatin complex.

Hoagland (Col.), Robert J. (M.C.), Chief of Medical Service, U. S. Army Hospital, Ft. Benning, Ga., and Henry M. Henson, "Splenic Rupture in Infectious Mononucleosis," *Ann. Int. Med.*, 46:1184-91 (June) 1957.

A review of previously published case reports of splenic rupture in mononucleosis disclosed that the recognition of this complication is usually delayed. In both of the cases reported splenic rupture was not diagnosed promptly. Underlying the delay is the fallacy that mononucleosis is "protean," and therefore abdominal pain need not be significant in an illness of many appearances.

The authors emphasize that abdominal pain, even mild, is uncommon in mononucleosis; and if pain is more than mild, splenic rupture must be suspected. Pain may be episodic. It may radiate toward the left shoulder. Eventually the pulse rate rises and signs of peritonitis and peritoneal fluid are evident. The diagnosis should be apparent before the blood count reveals a drop of hemoglobin.

A study of reported cases revealed that splenic rupture usually occurs ten to twenty days after the onset of mononucleosis, so the lymph node enlargement and characteristic hematology of the disease are present (and the heterophile antibody reaction is usually positive) by the time splenic rupture occurs. The diagnosis of mononucleosis should be apparent, if it has not already been made.

Knowledge of the significance of left upper quadrant abdominal pain especially when associated with an increasing pulse rate, or shock, in patients with mononucleosis will lead to earlier recognition of splenic rupture, earlier operation, and saving of lives.

AUTOMOTIVE CRASH INJURY RESEARCH

AUTOMOBILE CRASH INJURY RESEARCH has been initiated by the Department of Public Health and Preventive Medicine of Cornell University Medical College to identify those items which are causing injury or death to occupants of passenger cars involved in accidents. Prior to the initiation of this research program, causes of accidents were thoroughly investigated—causes of injuries were ignored.

In an attempt to fill this gap in our knowledge, an interstate cooperative research program has been established. For more than four years this new data-gathering system has been functioning with the active participation of state departments of public health, state medical societies, state hospital associations, and state police and traffic enforcement departments in fifteen other states. Using Cornell's specially designed research forms, these groups submit specific injury and accident damage details on all injury-producing passenger car accidents in selected sampling areas. This method uses the highway as a laboratory where the phenomenon of impact injury may be examined in its natural environment.

Here is how the sampling plan works in your area which, in this instance, is limited to the study of *only 1956, 1957, and 1958 passenger cars*:

1. An officer of the Georgia State Patrol conducts his routine accident investigation and determines and records the specific causes of injury to the occupants. Photographs of car interior and exterior are taken.
2. The officer then delivers to the private physician's office or to the emergency room of the hospital where the patient has been taken for treatment a special medical form to be completed by the attending physician. On the face of the form, the State Patrol record the date and location of accident, and the seated position of the patient in the automobile. Since all information furnished by physicians is treated as privileged medical infor-

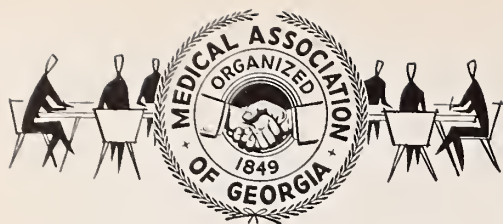
mation, to protect the identity of the patient, his name will appear on a perforated section of the form. This section is destroyed after the case has been analyzed and the medical data recorded by Cornell University Medical College.

3. After the brief form has been completed, it is mailed to the address which appears on the face of the form.
4. The data obtained is analyzed and evaluated at Cornell University Medical College and recorded on IBM cards for biometrical and engineering research on the causes of crash injuries.

Improved design in passenger cars is the goal toward which the automotive research study is directed. Toward this end, the data obtained by the program is released in technical reports which are made available to interested medical, automotive, military, insurance, and safety groups. Data produced by this study has already been used by automotive manufacturers. Such safety design innovations as improved door-holding mechanisms, use of new materials for effective energy absorption in padding, seat belts, etc., have been directly influenced by findings of the Interstate Automotive Crash Injury Research study.

Nineteen local Medical Societies which have been notified of the MAG's desire to cooperate with the program of the Automotive Crash Injury Research which will start December 1 in 46 counties in Georgia are as follows:

Sumter	Colquitt	Decatur	Wilcox	Crawford
Marion	Cook	Seminole	Dooly	Houston
Schley	Berrien	Bibb	Irwin	Taylor
Randolph	Lowndes	Peach	Crisp	Upson
Terrell	Lanier	Macon	Turner	Pulaski
Stewart	Grady	Tift	Lee	Bleckley
Webster	Thomas	Clay	Baker	Echols
Dougherty	Brooks	Calhoun	Pike	Miller
Mitchell	Worth	Early	Quitman	Ben Hill
Chattahoochee				



the association

MAG COMMITTEE ON LEGISLATION, September 26, 1957

THE FIRST FULL meeting of the 1957-58 Committee on Legislation of the Medical Association of Georgia was called to order at 5:30 p.m., Thursday, September 26th in the MAG Headquarters Office, Academy of Medicine, Atlanta, by Chairman J. Frank Walker, Atlanta.

Present, in addition to Dr. Walker, were: M. Freeman Simmons, Decatur; Virgil B. Williams, Griffin; Chris J. McLoughlin, Atlanta, MAG Secretary-Treasurer; Mrs. Ruth Inglis, State Chairman for Legislation, Woman's Auxiliary to the MAG; and Mr. John F. Kiser.

The minutes of a preliminary meeting of the Committee held on September 11th were approved as read by Mr. Kiser.

Report of the Chairman

Dr. Walker stated that there were no specific instructions from the House of Delegates, but that a number of matters had been referred to other committees which might eventually refer them to the Committee on Legislation.

Appointment of Keymen

Dr. Walker discussed the ten proposed keymen, one from each congressional district and read the proposed letter to be sent to these keymen. Several suggestions were made in regard to the letter, and these were noted in the revised version of the letter to be sent out.

Institutional Licenses

Mr. Kiser discussed the bill sponsored by the State Board of Medical Examiners providing for institutional licenses for physicians from unapproved medical schools.

Miscellaneous State Legislation

Mr. Kiser discussed several items of miscellaneous bills left over from the 1957 session of the Georgia General Assembly. He was instructed to collect additional information and data in regard to the premarital bill which is in the House of Representatives.

Mr. Kiser and Dr. Walker also discussed several matters concerning Workmen's Compensation which have been brought up. Dr. Walker pointed out that all of these matters had been referred to the Industrial Health Committee of the MAG.

Report on National Legislation

In the absence of Dr. Allen, Co-Chairman for National Legislation, Mr. Kiser reported on the HR 9467, a bill which would provide free hospital and surgical care for every person eligible for benefits under the Old Age and Survivors Insurance program of the Social Security Act. Mr. Kiser relayed certain information which was received from the AMA in regard to this piece of legislation which was introduced in Congress on August 27, 1957.

Activities of the Woman's Auxiliary

Mrs. Onglis of Marietta reported on the activities of the Woman's Auxiliary Committee.

She stated that the State Committee of the Woman's Auxiliary had sent out letters to all district and county society legislative committee chairmen urging them to keep informed through national and state publications and newsletters. Also, quarterly, articles will be published in the State Auxiliary Newsletter, according to Mrs. Onglis. Local societies were urged to invite legislators to their auxiliary meetings, and other general activities were outlined.

There being no further business, the meeting was adjourned.

RURAL HEALTH September 22, 1957

RURAL HEALTH COMMITTEE CHAIRMAN J. Lee Walker called the meeting of the Association Rural Health Committee and Rural Health Committee Advisory Board to order at 1:15 p.m., September 22, 1957, Academy of Medicine, Atlanta.

Committee members present included: Charles T. Brown, Guyton, 1st District; M. F. Arnold, Hawkinsville, 3rd District; John P. Heard, Decatur, 5th District; H. R. Cary, Milledgeville, 6th District; George H. Alexander, Forsyth, 6th District; H. C. Derrick, LaFayette, 7th District; Sage Harper, Douglas, 8th District; J. Lee Walker, Clarkesville, Chairman, 9th District; and, Hugh B. Cason, Warrenton, 10th District.

Rural Health Committee Advisory members present included: Rev. Edward A. Driscoll, Georgia Council of Churches; William A. King, Extension Service, University of Georgia; Marion Fisher, Assistant State 4-H Leader; Mrs. E. S. Cowan, Jr., Home Demonstration Council; Miss Lucile Higginbotham, Agricultural Extension Service; and, Mr. Albin Maret, Jr., Georgia Farm Bureau. Also attending was Mr. M. D. Krueger, Association Executive Secretary.

Chairman Walker reported on the American Medical Association Council on Rural Health activity, and reviewed the activity and projects of the Association Rural Health Committee since the last meeting.

Health Record Cards and Annual Physicals

General discussion ensued about the health record cards now being distributed and the policy of recommending annual physicals to the public. It was recommended that the Association advise all members about the distribution of the cards and the emphasis the committee was trying to exert in urging the public to seek annual physical examinations.

Hospital Chaplains

Mr. Driscoll reported on the progress being made in cooperation with the local hospitals in establishing a chaplain system for the hospitals in Georgia. He reported that this activity is now underway and he stated that he will have a further report at a later date on the progress of this project.

Film Library

The problem of establishing a film library with loaned films from the American Medical Association was referred to Dr. J. Lee Walker who was requested to discuss this problem with Mr. Aubrey Gates of the American Medical Association. It was emphasized that at least six months loan period be requested with a renewable option at the discretion of the AMA to effectively distribute the films in Georgia. Records would be kept of each film showing and submitted to AMA on the basis of distribution.

Insurance Information Booklet

Dr. Walker reported that Dr. Charles S. Jones, Co-Chairman of the Association Insurance and Economics Committee was formulating a health insurance booklet to be distributed to the public. It was emphasized that this booklet should explain the insurance will not pay everything, and further that certain insurance will not cover pre-existing conditions. It was further requested that the booklet emphasize that the patient should read his policy and his policy application so that the patient may be aware of just what type of coverage he has at the time he buys said coverage.

Recruitment Pamphlet

Dr. John Heard reported that he had gained information about the various para-medical educational opportunities and that this project was well underway. Dr. Heard advised the committee that more time would be needed to complete the project and that the matter of finances for this recruitment pamphlet project was as yet unsolved.

Weekly News Column

Dr. Derrick reported on the weekly news column project on health-related subjects, and gave data concerning 31 dailies and 197 weeklies and seven semi-weeklies. He emphasized that the releases should be aimed at weeklies; that a backlog of articles must be written before the project begins; that an editorial committee should be appointed to screen material; that a professional writer be employed to re-write the material originally written by a physician; that the series should be introduced to the papers and to the public before the project starts; and that separate series of articles be used for dailies later if the initial project with the weekly newspapers is successful.

Advisory Council

Chairman Walker then called for comment and new projects from the Advisory Council.

(1) It was recommended by the Advisory Council that a health certificate for campers to be filled out by family physicians, and Dr. Maurice Arnold was requested to prepare such a health certificate form for Miss Higginbotham.

After discussion of this activity the joint meeting

was adjourned, and members of the Rural Health Committee convened to discuss other projects. These projects included the insecticide pamphlet; the medical school course committee report; Junior Day at both the Medical College of Georgia and the Emory University School of Medicine. Chairman Walker appointed Maurice F. Arnold to head the Junior Day at the Medical College of Georgia, and Dr. George Alexander to head the Junior Day at Emory University School of Medicine. Mr. Krueger was instructed to write Mr. Hallum of Meade Johnson Co., about the Junior Day and medical school course projects.

It was approved that April 13, 1958 be set as the next date for a joint meeting of the Rural Health Committee and the Advisory Board to the Rural Health Committee, to be held in Atlanta.

It was also approved that February 16, 1958 be set for a meeting of the Rural Health Committee to be held in Atlanta.

The meeting was adjourned at 4:10 p.m.

INDUSTRIAL HEALTH October 10, 1957

INDUSTRIAL HEALTH COMMITTEE Chairman Robert M. Harbin, Rome, called the meeting of the Association Industrial Health Committee to order at 1:35 p.m., October 10, 1957.

Members of the Committee present included: Chairman Robert M. Harbin, Rome, and T. A. Peterson, Savannah. Also meeting with the Committee were: J. Frank Walker, Atlanta, Chairman of the Association Legislation Committee, and Albert M. Deal, Statesboro, member of the Legislation Committee. Messrs. Krueger and Kiser of the Headquarters Office also met with this Committee.

California Relative Value Fee Schedule

Chairman Harbin opened the meeting with a discussion of the California Relative Value Fee Schedule. Dr. Harbin indicated that as the Association has numerous fee schedules for various aspects of a physician's practice such as Medicare, VA Home Town Care Program, Workmen's Compensation, etc., that the Association should make full use of the California Relative Value Schedule and that the Association should consider a master Georgia Relative Value Schedule for use by committees of the Association dealing with fee schedules on a statewide basis.

Workmen's Compensation Act Fee Schedule

Chairman Harbin brought to the attention of the Committee various complaints from physicians in Georgia concerning the present State of Georgia Workmen's Compensation Fee Schedule adopted by the Georgia Industrial Board, April 15, 1952. It was stated that some of the fees listed in this fee schedule were at the present time inequitable. The Committee decided that certain equitable changes should be considered rather than a complete revision of the schedule. Proposed changes were made in the 1952 State of Georgia Workmen's Compensation Act fee schedule, and it was recommended that these changes be submitted to the Council of the Medical Association, and if approved, then the

same changes to be submitted to the appropriate authority of the Georgia State Board of Workmen's Compensation.

Workmen's Compensation Law

Chairman Harbin then discussed freely with the Committee the present procedure under the Georgia Workmen's Compensation Act concerning the freedom of selection of physicians by employee.

These provisions were clarified and Dr. Deal stated that he believed these provisions restricted the freedom of choice of physicians by the patient. After discussion of this subject, the Committee voted to: "ask the Council of the Medical Association of Georgia to recognize that this problem exists and to take steps to preserve the patient-physician relationship." This statement was approved and it was requested that it be presented to the Council.

There being no further business, the meeting adjourned at 5:00 p.m.

PUBLIC SERVICE COMMITTEE

October 13, 1957

PUBLIC SERVICE COMMITTEE CHAIRMAN John P. Heard, Decatur, called the meeting of the Association Public Service Committee to order at 1:45 p.m.

Members of the Committee present included: John P. Heard, Decatur, Chairman; E. P. Inglis, Marietta; E. C. McMillan, Macon; A. H. Letton, Atlanta; Thomas E. DuPree, Bainbridge. Also present were: Dr. J. L. Walker, Clarkesville, Chairman of the Association Rural Health Committee; and Dr. H. C. Derrick, LaFayette, member of the Rural Health Committee; Mr. Joseph Hall, Professional Writer; and Mr. Milton D. Krueger, Executive Secretary.

Weekly Newspaper Health Column

Mr. Joseph Hall, professional news writer, led a discussion concerning the Association's sponsorship of weekly health columns to be published in the weekly newspapers in Georgia. Dr. J. Lee Walker reported that his Rural Health Committee was highly in favor of such a project and had discussed it at their recent meeting. It was recommended that such a project be co-sponsored by the Association Public Service Committee and the Association Rural Health Committee, and that the cost estimated for this project would be approximately \$3,000 per year. It was suggested that each of these two committees seek Association appropriations of \$1,500 to provide the estimated expense entailed in this project.

Emergency Call Systems

It was agreed that a letter of reminder to the Association component county societies be sent requesting cooperation in maintaining or establishing an emergency call system.

Annual Press Award

Chairman Heard discussed the possibility of initiating an annual cash award to newswriters for outstanding medical news coverage and Dr. A. H. Letton was appointed to investigate the possibility of such an award and to report back to the Committee. Dr. Letton was also requested to investigate the possibility of such an award for outstanding lay contribution to the field of medicine.

Newspaper Medical Supplement

Chairman Heard discussed the possibility of a medical supplement for Sunday newspapers and stated he would further investigate the possibility of such a project.

MAG Speakers' Bureau

After discussion of the advantages of an MAG Speakers' Bureau providing speakers for lay groups, it was recommended that the availability of medical speakers be made known by a paragraph at the end of each weekly newspaper health column.

Public Service Booklets

Chairman Heard informed members of the Committee that a MAG member indoctrination booklet was in the process of being written, giving detailed information about the Association and its services. Chairman Heard believed this in the field of internal public relations, and further informed members of the Committee that other booklets of a similar nature were contemplated, i.e.: How to be a Component County Medical Society Officer; How to be an MAG Delegate; How to be an MAG Committee Chairman; etc.

Auto-Highway Safety

Chairman Heard discussed with members of the Committee the priority to be given by the Committee in emphasizing auto-highway safety. It was agreed that as a basis for such a program, driver education training; stricter driver's license laws, and revocation of same; and annual vehicle inspection were necessary adjuncts to highway safety. Dr. Heard informed the Committee that he would meet with Colonel Dominy of the Georgia State Patrol to discuss this subject further and report back to the Committee.

State Fair Exhibit

Chairman Heard expressed his feeling of the need for an Association State Fair Exhibit, and it was agreed that this project should be undertaken and Dr. Peter Inglis was appointed to promote this project.

Public Service Program

Chairman Heard expressed the desire of the Committee for adequate time on the MAG Annual Session program to inform the doctors of Georgia about the tremendous need for public relations and public service by the profession. It was agreed that Dr. Heard would confer with Maurice F. Arnold, Hawkinsville, President of the Georgia Academy of General Practice, concerning the possibility of staging such a program at the Annual Session GP Day reconvened time.

The next meeting for the Public Service Committee was set for Sunday, January 12, 1958, 2:00 p.m., Dempsey Hotel, Macon, Georgia.

There being no further business, the meeting was then adjourned.

ANNOUNCEMENTS

Six Days of Cardiology—Emory University School of Medicine, January 13-18, 1958. Major problems of heart disease will be discussed by members of the Emory University faculty and visiting doctors. Tuition fee, \$100. For further information write to the Postgraduate Teaching Program, Emory University School of Medicine, 69 Butler Street, Atlanta 3, Ga.

Gastro-enterology—Duke University School of Medicine, Durham, N. C., February 10-14, 1958. Sponsored by the American College of Physicians. Course is designed to cover the clinical aspects of the important diseases of the gastro-intestinal tract. Patients illustrating disease will be shown when available. Panel discussions will be employed. Fees: \$30.00 for A.C.P. members; \$60.00, non-members. For further details contact Julian M. Ruffin, M.D., Director Duke University School of Medicine, Durham, N. C.

Selected Problems in Internal Medicine—The University of Southern California School of Medicine, February 17-21, 1958. Sponsored by the American College of Physicians. Each of the five days will be devoted to a different phase of internal medicine. Patients will be used in discussions. Part of each day devoted to seminars, ward rounds, and clinics. Fees: members of A.C.P., \$30.00; non-members, \$60.00. For full details contact Thomas H. Brem, M.D., University of Southern California School of Medicine, Los Angeles, Calif.

American College of Chest Physicians, Interim Session—Warwick Hotel, Philadelphia, Pa., December 2-3, 1957. Lectures, panels, round table discussions, and informal fireside conferences will compose program. All physicians are invited. There is no registration fee: For further information write American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

New Orleans Graduate Medical Assembly—Roosevelt Hotel, New Orleans, La., March 3-6, 1958. Eighteen outstanding guest speakers will present topics of interest to both specialists and general practitioners. Program will include discussions, clinicopathologic conferences, symposia, medical motion pictures, round table lunches, and technical exhibits. Following the meeting, there is a postclinical tour to Mexico City, Guernavaca, Taxco, and Acapulco. Assembly is Category I approved. Details are available at the office of the Assembly, Room 10c, 1430 Tulane Ave., New Orleans, La.

Fifth International Congress on Diseases of the Chest—Sponsored by the American College of Chest Physicians—Tokyo, Japan, September 7-11, 1958. Scientific papers, panel discussions, fireside conferences, and motion pictures will be presented. Registration fee: \$25.00 for each physician and \$10.00 for each family member. For additional information write Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Sectional Meeting of the American College of Surgeons—Hotel Heidleberg, Jackson, Mississippi, January

16-18, 1958. Topics for consideration will include "Complications of Abdominal Surgery," "Chemotherapy," "Metastasis and Limitations of Surgery for Cancer," "Common Errors in Management of Fractures," etc. Motion pictures to be shown daily. For complete details contact the American College of Surgeons, 40 East Erie Street, Chicago 11, Illinois.

Research Training in Pathology—Department of Pathology, New York University—Bellevue Medical Center. Eight research fellowships available for trainees at the level of assistant resident. Stipend from \$3, 600 to \$4, 500 yearly. Two senior fellowships available for physicians with a more advanced level of training. Stipend of \$7, 5000 annually. Program planned so that trainee can interrelate research investigations with clinical and pathology activities. For further information write to the Office of the Dean, New York University College of Medicine, 500 First Avenue, New York 16, New York.

DEATHS

FRANK L. CORLEY, Atlanta, died October 7 in a private hospital. Born in Alabama, Dr. Corley graduated from Emory University School of Medicine in 1915 and interned at Grady Hospital.

He was visiting physician to the Georgia Confederate Soldiers Home in Atlanta from 1915 to 1935 and served as examining physician for the Metropolitan Life Insurance Company from 1917 until 1955.

Dr. Corley served as a member of the Board of Medical Examiners during World War II. He was a member of the Fulton County Medical Society, Medical Association of Georgia, Southern Medical Association, and American Medical Association.

Survivors include his wife; two sons, F. L., Jr., and Judson A. Corley, Atlanta; and four sisters.

FRANK ESKRIDGE, SR., Atlanta, died unexpectedly of a heart attack on October 9 at the age of 71. Born in Atlanta, Dr. Eskridge attended the old Boys High School and Atlanta Medical School, now Emory University School of Medicine. After receiving his medical degree, he attended the Atlanta Law School and was admitted to the Georgia Bar. At the time of his death, Dr. Eskridge was Atlanta's only practicing surgeon who also held a law degree. He had taught medical jurisprudence at Emory and was on the faculty of the Atlanta Law School.

Dr. Eskridge was chief of staff of the department of obstetrics and gynecology at Grady Hospital. He was a cofounder and dean of the Oglethorpe Medical School during its period of existence, a charter member of the International College of Surgeons, and a member of the American Medical Association, the Medical Association of Georgia, and the Fulton County Medical Society.

Surviving are his wife; two sons, Dr. Frank Eskridge, Jr., and Major Frank Eskridge, Atlanta; one sister; and five grandchildren.

EUGENE B. FERRIS, JR., Medical Director of the American Heart Association and former chairman of the Department of Medicine at Emory University School of Medicine, died September 26, in New York

DEATHS / continued

City. Dr. Ferris was 52 years old at the time of his death.

A native of McNeil, Mississippi, Dr. Ferris came to Atlanta in 1952 from the University of Cincinnati where he had been professor of medicine and a director of a commonwealth fund psychosomatic teaching program.

He had attended Mississippi State College and received his medical degree from the University of Virginia. He was a member of the Board of Regents, the American College of Physicians, a former president of the American Society for Clinical Investigation and a former president of the American Psychosomatic Society.

While serving as a consultant to the Surgeon General of the United States Army during World War II, Dr. Ferris became a pioneer in the studies of the effects of high altitudes on humans.

Survivors include his wife, two daughters, and one son.

SOCIETIES

Members of the CHEROKEE-PICKENS MEDICAL SOCIETY were entertained recently with a dinner given by Dr. and Mrs. Arthur M. Hendrix of Canton.

The ELBERT-FRANKLIN-HART MEDICAL SOCIETY held its second meeting October 2 at the Samuel Elbert Hotel. At this meeting Dr. Ralph Hogan, Chief of Laboratory Branch of Communicable Disease Center, U. S. Public Health Service, gave a short talk on Asiatic Influenza.

At a meeting of the THOMAS-BROOKS COUNTY MEDICAL SOCIETY, C. K. Wall, who leaves to make his home in Tallahassee, Florida, was presented with a silver trophy by members of the society. At this same meeting Donald S. Bickers, Atlanta, gave a paper on "Diagnosis and Management of Convulsive Disorders."

The semi-annual meeting of the SECOND DISTRICT MEDICAL SOCIETY was held October 3, 1957 at Radium Springs in Albany, Georgia. At this meeting the following scientific papers were read: "Fractures About the Elbow Joint in Children" by John A. Meier, Albany; "Practical Approach to Hemorrhagic Problems in General Practice" by H. E. Aderholt, Tifton; and "Bedside Observations in Heart Disease" by John W. Hurst, Emory University.

The SEVENTH DISTRICT MEDICAL SOCIETY had its annual fall meeting last October in Cartersville. Prior to the business session, a social hour for guests was held at the Cartersville Country Club. At the regular meeting four scientific papers were presented by the following doctors: Nan E. Robinson of Rome; Cary Moore, Rome; McClaren Johnson, Atlanta; and Arthur J. Merrill, Atlanta.

The GEORGIA MEDICAL SOCIETY, Savannah,

recently sponsored Joseph K. Bradford of New Orleans as speaker at an October meeting of the society. Dr. Bradford is Director of the Cardio-Pulmonary Laboratory, Oschner Foundation.

The MUSCOGEE MEDICAL SOCIETY recently sponsored a symposium on the subject of progress in the fight against cancer. The symposium featured discussions of three case histories presented by W. H. Newsum of the Columbus Tumor Clinic; Kenneth Grace of West Georgia Cancer Clinic, and A. B. Conger, Columbus Tumor Clinic. At the same meeting, Charles M. Huguley, Jr., Emory University School of Medicine, discussed the use of chemicals in cancer treatment.

PERSONALS

At the annual meeting of the Georgia Chapter of the American College of Surgeons, the following new officers were named: JOSEPH READ, President; THOMAS GOODWIN, Augusta, Vice-President; DUNCAN SHEPARD, Atlanta, Secretary; and WILLIAM WHITAKER, Atlanta, Treasurer.

First District

The *Journal* regrets to announce the death of Ellison R. Cook, II, father of ELLISON R. COOK, III, Savannah.

Announcement has been made of the recent opening of the Memorial Clinic in Statesboro to be occupied by ALBERT DEAL and HELEN READ DEAL. Joining the Drs. Deal in the clinic are Lindsey Frank Lovett and Katherine Simmons Lovett. The clinic is located at the corner of East Grady and Donehoo streets.

Announcement has been made of the association of THOMAS R. FREEMAN and WILLIAM H. LIPPITT of Savannah for the practice of general surgery. Their newly constructed offices are located at 200 Thirty-first street.

JULIAN K. QUATTLEBAUM, Savannah, recently attended the 55th annual session of the Association of Seaboard Air Line Railway Surgeons in Richmond, Virginia. Dr. Quattlebaum is the second vice-president of the association.

W. K. SMITH, Pembroke, was honored recently by a stag luncheon given by his wife and his son, W. E. SMITH. The occasion for the luncheon was Dr. Smith's 74th birthday.

Second District

A memorial honoring the late L. A. SMITH, Quitman, has now been completed. With funds contributed by friends and family, the nursery of the Brooks County Hospital has been renovated and new equipment bought.

Third District

JOHN W. MAYHER, Columbus, was married recently to the former Mrs. Buena Culpepper, daughter of the Rev. Guy H. Veazy of Elon College, N. C. The couple are now residing on River Road in Columbus.

J. T. ARNOLD, Dawson, was recently honored with a covered dish supper given as a surprise celebration of his 82nd birthday.

T. SCHLEY GATEWOOD, Americus physician, delivered the principal address at the graduation exercises for the Department of Nursing at Georgia South-west College.

Fourth District

THOMAS BROWN, Thomaston pediatrician, was the guest speaker at a recent meeting of the Upson County Nurses' Association. Dr. Brown spoke on nursery school work.

CLAUDE H. FOWLER, JR., has recently joined the staff of the Forest Park Clinic. Since 1953 Dr. Fowler has served on the teaching staff of the Emory University School of Medicine.

Fifth District

J. H. KITE Decatur orthopedic surgeon, was guest speaker at a meeting of the Savannah Scottish Rite bodies recently. Dr. Kite's talk included photos on work done at the hospital and a demonstration of several former patients.

HARRIET E. GILLETTE, Atlanta specialist in physical medicine, has been elected secretary of the American Congress of Physical Medicine and Rehabilitation. The election was held at a meeting of the Congress in Los Angeles. At this meeting, Dr. Gillette won second prize for her exhibit entitled "Total Management of Muscle Dysfunction." She was also presiding officer of one of the general scientific sessions during the meeting.

Seven Atlanta doctors were presented medallions from the Georgia Heart Association in recognition of outstanding service in the fight against heart disease. Honored were R. BRUCE LOGUE, T. STERLING CLAIBORNE, CARTER SMITH, J. LAMONT HENRY, JOSEPH C. MASSEE.

J. R. EVANS, Stone Mountain, has been elected chairman of the board of directors of the DeKalb Hospital Authority.

Atlanta psychiatrist RIVES CHALMERS was the principal speaker at the first annual membership meeting of the Floyd Mental Health Chapter held in October. Dr. Chalmers also participated in a forum at the same meeting.

ROBERT L. BROWN, Emory University Clinic Department of Surgery, was recent guest speaker at a meeting of the Cancer Society held in Cornelia.

DANIEL D. HANKEY, Atlanta, has been elected President of the Atlanta Rheumatism Society at the society's fall meeting. Other officers elected were: DAVID F. JAMES, Vice-President; and JOHN deR. SLADE, Secretary-Treasurer.

T. STERLING CLAIBORNE, Atlanta, presided at the opening session of the annual Southeastern Regional Meeting of the American College of Physicians held recently in Brunswick.

R. BRUCE LOGUE, Emory University, was guest lecturer at the program of the Southwest Clinic Society, Kansas City, Missouri. The subjects of his talks were: "Treatment of Acute Cardiac Emergencies," and "Errors in the Diagnosis of Chest Pain." Dr. Logue also participated in a symposium on "Recent Advances in Heart Disease."

DONALD S. BICKERS, Atlanta, attended a meeting of the American Electroencephalographic Society in Santa Fe, New Mexico, in October, at which time he presented a paper on "Cortical Excision for Focal Seizures Under General Anesthesia." Dr. Bickers also attended the Congress of Neurological Surgeons held November 6-8 in Washington, D. C., and the Southern Electroencephalographic Society meeting in Miami, Florida, November 9-10.

Sixth District

CHARLES B. FULGHUM, Milledgeville, was a panel speaker at a recent meeting of the Parent-Teacher Association of Peabody School. Dr. Fulghum discussed the physical phase of a child's development.

Wilbur E. Baugh, brother of JAMES E. BAUGH of Milledgeville, has opened offices for general practice of medicine near the Baldwin County Hospital in Milledgeville.

W. CHARLES BOSWELL, Macon pediatrician, spoke to a recent meeting of the Macon Civitan Club on the subject of Asian Influenza.

The Coleman Building, formerly the Coleman Hospital in Dublin has been rebuilt and renovated into a modern office building which is dedicated to the memory of the late ALFRED TENNYSON COLEMAN, who for many years served as Dublin physician. Dr. Coleman located in Dublin in 1920 and built his first hospital in 1934. He served as county physician for 20 years and city physician for a number of years. Dr. Coleman at one time held the office of Senator of that district.

Seventh District

The *Journal* regrets to announce the death of Mrs. Vinnie Neal Sams, 83, wife of H. L. SAMS of Dalton.

Dr. and Mrs. CLAUDE V. VANSANT, JR., recently entertained a group of Dr. Vansant's former medical school classmates at their home in Douglasville. Those present for the occasion included Dr. and Mrs. EU-



Pictured here are members of the Committee on Civil Defense which met in Atlanta recently. Standing, from left to right: Harold C. Lueth, M.D., Evanston, Ill., Chairman; Earle Stondlee, M.D., Chicago; Frank W. Borton, Chicago; Corroll P. Hungate, M.D., Kansas City, Mo. Seated, left to right: Charles W. Steele, M.D., Lewiston, Me.; Roscoe L. Sensenich, M.D., South Bend, Indiana; David Henry Poer, M.D., Atlanta; Cortez E. Enloe, Jr., M.D., New York.

PERSONALS / continued

GENE TANNER, Marietta; Dr. and Mrs. BILL PURCELL, Calhoun, and Dr. and Mrs. LAMAR B. PEACOCK, Atlanta.

E. A. MUSARRA, Marietta, was recently named president of the Cobb County Chamber of Commerce. Dr. Musarra has been active in civic affairs since coming to Marietta in 1938. At present he is president of the Marietta Touchdown Club, a director of the Marietta Kiwanis Club, and team physician for the Marietta High and Sprayberry football teams.

Eighth District

ARTHUR KNIGHT, JR., Waycross, has been cited by the Georgia Heart Association for "meritorious service." He was presented with a medallion at a recent state meeting of the Association in Savannah. Dr. Knight, a specialist in cardiovascular diseases, organized the Waycross and Ware County Heart Clinic.

E. ADAMS DANEMAN, Waycross, psychiatrist, was a participant at the 35th anniversary celebration of the Child Guidance Center, Worcester, Mass. Dr. Daneman was a discussant at the three-day session which brought together many world figures in the field of child psychology including Dr. Anna Freud, daughter of Sigmund Freud.

J. M. JACKSON, Folkston, has been joined in the practice of medicine by Edward S. Lundell, formerly of Jacksonville, Florida. Dr. Lundell was a general practitioner in Jacksonville and a staff member of the five Jacksonville hospitals.

Ninth District

The following Toccoa doctors have become associated with the newly formed Medical Arts Clinic: R. H. CHANEY, JR., H. H. McNEELY, M. D. PITTARD, R. E. SHIFLET, and W. B. SCHAEFER.

BEN K. LOOPER, Canton, has recently been appointed as a member of the State Board of Health. Dr. Looper has operated the Cherokee Clinic and Ma-

ternity Hospital in Canton since 1951. He is the past secretary-treasurer of the Georgia Academy of General Practice.

Tenth District

ROBERT B. GREENBLATT, Augusta, recently presented a paper entitled "Sexual Abnormalities in Man" before the Laurentian Hormone Conference at Mont Tremblant in Quebec, Canada.

GOODLOE Y. ERWIN, Athens, was elected President of the Georgia Heart Association for the coming year at the ninth annual session held at Savannah. Dr. Erwin is a charter member of the Association and has been active in its development since its founding in 1948. He is former chief of the Athens Heart Clinic, past president, and past chairman of the Board of Directors of the Northeast Georgia Chapter of the Georgia Heart Association. He was instrumental in the development of the clinic and in the development of the entire heart program in the Northeast Georgia area. He has served on the Georgia Heart Association Executive Committee and as Chairman of the Budget Committee for several years.

HOWARD C. MCGINTY, Augusta, has been appointed to the advisory board of directors of the Early American Insurance Company of Atlanta.

VIRGIL PRESTON SYDENSTRICKER, Augusta, has been named emeritus professor and emeritus chairman of the Department of Medicine of the Medical College of Georgia. Dr. Sydenstricker retired from the Medical College in July of this year after serving as Professor of Medicine for 35 years. Since his retirement, he has been appointed to the staff of the Veterans Administration Hospital in Augusta.

CORBETT H. THIGPEN, Augusta, coauthor of the book "Three Faces of Eve", was guest speaker at a meeting of the Atlanta Writers' Club recently.

HOKE WAMMOCK, Augusta, recently presented a paper at a meeting of the International College of Surgeons in Chicago. Dr. Wammock's paper was entitled "Radical Surgery for Intra-Oral Cancer."

GEORGIA, FULTON COUNTY
STATE BOARD OF MEDICAL EXAMINERS
VS
DANIEL SINGLETON LAWRENCE, M.D.
Menlo, Georgia

*Order and notice to show cause
why license to practice medicine
in this state should not be
revoked; hearing and order.*

The foregoing matter coming on regularly to be heard before the State Board of Medical Examiners, after due notice, in Room 201, State Agricultural Building, Atlanta, Georgia; the respondent, Doctor Daniel Singleton Lawrence was not present and was not represented by his Attorney. After examining the evidence submitted, the plea of not guilty, verdict of the jury, the indictment and sentence of the Court, the Board unanimously determined that good and sufficient evidence had been submitted to revoke the license to practice medicine of the said Doctor Daniel Singleton Lawrence.

Now, therefore, it is considered, ordered and adjudged that the license of Doctor Daniel Singleton Lawrence to practice medicine in Georgia, be, and the same is hereby revoked under and by virtue of the authority vested in said Board by the laws of Georgia. It is further ordered that any Clerk of the Superior Court in whose office said license is recorded, is hereby ordered and directed to cancel the record of said license by entering upon the face thereof a certified copy of this order.

This the 10th day of October, 1957.

STATE BOARD OF MEDICAL EXAMINERS OF GEORGIA.

LAW DEPARTMENT

AMERICAN MEDICAL ASSOCIATION

October 1, 1957

Principles of Medical Ethics, 1957, American Medical Association Section 3:

"Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle."

The 1955 edition of *The Principles*, Chapter II, Section I, read as follows:

"Duties of Physicians to Their Patients Standards, Usefulness, Nonsectarianism"

"Section 1.—In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end he should not base his practice on an exclusive dogma or a sectarian system, for 'sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought.' A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience. All voluntary associated activities with cultists are unethical. A consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training, and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice."

The Judicial Council has expressed the opinion that the interpretations of Chapter II, Section 1 of the 1955 edition of the *Principles* are valid and binding under Section 3 of the 1957 edition of the *Principles*.

Action of House of Delegates on "Report of Committee for the Study of Relations Between Osteopathy and Medicine" at its Atlantic City session, 1955. (See pages 737-741, J.A.M.A., July 2, 1955).

The report of the committee was received and filed, the committee thanked and discharged. The door was left open for further consideration "if and when the House of Delegates of the American Osteopathic Association, its official policy making body, may voluntarily abandon the commonly so-called 'osteopathic concept.' Then it may approach the Board of Trustees of the American Medical Association with request for further

discussion of the relations between osteopathy and medicine."

Report of the Judicial Council to House of Delegates at the Boston session 1955.

"It appears to the Judicial Council that the House of Delegates by discharging the Committee to Study Relations between Osteopathy and Medicine has not changed its policy in regard to the relationship of members of the American Medical Association with osteopaths. Therefore, the Judicial Council reaffirms the statement in its 1952 annual report: 'Thus in the absence of a directive from the House of Delegates and in the absence of any alternative statement from the osteopaths themselves that they no longer adhere to their original cult theories, the Judicial Council reasserts its opinion that all voluntary associations with osteopaths are unethical.' Only the House of Delegates can alter this policy and, until the House is convinced that osteopathy is no longer a sectarian practice and so votes, it is incumbent on members of the Association to observe existing policy." (See J.A.M.A. October 29, 1955, p. 926 et seq.)

At the Boston session, 1955, the House of Delegates adopted the report of the Reference Committee on Miscellaneous Business, to which the report of the Judicial Council had been referred. The Reference Committee report, recommending adoption of the Judicial Council report, contains this statement "The Committee desires to call to the attention of the House, the conclusion of the Council that 'the *Principles of Medical Ethics* of the Association proscribe as unethical all voluntarily associated activities with cultists'" (See J.A.M.A. December 31, 1955, p. 1748).

Other Opinions of the Judicial Council

Other opinions of the Judicial Council expressed in official letters from the Council state that associations between doctors of medicine and osteopaths which are recognized by law or regulation of the state cannot be considered voluntary and consequently should not be considered contrary to the *Principles*.

It has further stated that there should be no consultation with osteopaths and if a doctor of medicine is called in on a case when an osteopath is in charge, the doctor of medicine may receive the report from the osteopath and then take the case over completely. When a specialist in medicine makes a medical report relating to an individual who is or may be under the care of an osteopath, the report can be submitted directly to the patient but it is unethical to deal directly with the osteopath. When a physician's former patient is under the care of an osteopath the physician may supply, through the patient, pertinent excerpts from the former patient's medical case record.

The Judicial Council at a meeting held on April

25, 1952, concurred in an action of the Los Angeles County, California, Medical Society, as follows:

"that, because of the current acute shortage of hospital beds in the Los Angeles area, it is not improper for members (of the medical associations) to hospitalize patients in certain of the smaller hospitals in outlying areas, even though in these hospitals facilities and privileges are also extended to certain osteopathic physicians and surgeons—provided that dual hospital staff structure is maintained without intermingling."

The Judicial Council expressed its reasons why associations between doctors of medicine and cultists are unethical in its annual report of 1936 which were repeated in its report of 1945. They head, in part as follows:

"There are several general ethical principles underlying cult practice in its relation to medical practice as carried out by doctors of medicine. Primarily the basis for an ethical code is the well being of the people at large, who are dependent on the profession of medicine for their health. The profession of medicine is the custodian of the accumulated knowledge in medicine and should use it for the benefit of humanity. This knowledge, technical in nature and developed by experience, can be interpreted to the body of the people only by persons educated to understand it and trained to apply it. Of all those professing to heal the sick only the doctor of medicine has sufficient education and training to make use of the information already accumulated and keep abreast of that being developed continuously. We grant that even though this is true no one is compelled to choose only from this group in selecting his medical attendants. The individual may elect to receive his medical care from himself, his neighbor, osteopathy, chiropractic, naturopathy, or Christian Science, but he is not entitled while under the care of such irregulars, to demand that the man educated in scientific medicine furnish opinion and advice to one so far deficient in education that he cannot so understand and apply that opinion and advice as to be able to make satisfactory use of it. Such degrading consultation would cheat the patient out of that which he might expect and the subsequent failure of results bring discredit on the science of medicine. If this is true of the occasional individual consultation, how much greater must it be in the case of repeated or continual miscegenation!

"The Judicial Council is in receipt of much correspondence attempting to justify if not to advocate consultations between doctors of medicine and chiropractors, osteopaths, Christian Scientists and other cultists, and irregular practitioners; also appearance before their societies, teaching in their schools, and their admittance to hospital practice on a parity with the medical profession. The universal argument for all the procedures mentioned is based on the false premise 'to work them gradually into regular

medicine.' One of our principles of ethics is as follows: 'The obligation assumed on entering the profession . . . demands that the physician use every honorable means to uphold the dignity and honor of his vocation, to exalt its standards and to extend its sphere of usefulness.' Such specious argument as mentioned above seems to the Council to lack substance and be unreal. It seems impossible that knowledge gained through years of scientific laboratory work and teaching can be assimilated by those of less preliminary training and use of scientific methods of investigation and practice ever to fit them to enter a profession, the dignity and honor of which, the standards and sphere of influence of which, we are obligated to uphold, exalt and extend for the service the profession can render to humanity. We further are of the opinion that it is just as impractical to suggest that the small percentage of cult practitioners will through close relationship with the membership of our profession be raised to our professional standards as it is to expect the few rot-speckled apples in the apple barrel to become whole because of the preponderance of sound ones. We believe in continuous, complete separation between the true and the specious physician. Our traditional responsibility for the dissemination of sound scientific treatment for the people and for protection against the insidious influence of the weaker among our own is ever present. If and when the time comes that government through legislation places the cultists on the same legal plane with us, we must strive to maintain the aristocracy of learning and culture. A physical and professional separation as complete as it is possible should be established and maintained."

There are two reports of the Committee for the Study of Relations Between Osteopathy and Medicine. Each was presented to the House of Delegates of the Association. The first may be found in *The Journal of June 20, 1953* pp. 734-740; the second appears in *The Journal of July 2, 1955* pp. 737-741.

There are 398 osteopathic hospitals of which 99 are on the "registered list" of the American Osteopathic Association, 87 are approved for the training of interns and 43 are approved for residency training. (See *Journal of American Osteopathic Association of September, 1956*, p. 59 'Report of Executive Secretary'). By way of comparison, in medicine 867 hospitals are approved for intern training. Residency programs in medicine are conducted in 1,202 general or special hospitals. (See *J.A.M.A. of September 22, 1956* p. 277 et seq.)

The Joint Commission on Accreditation of Hospitals accredits only those hospitals listed by the American Hospital Association. It is understood to be the policy of the American Hospital Association not to list any hospital which is staffed by others than doctors of medicine.

The above reports and interpretations are effective under the 1957 edition of the *Principles of Medical Ethics*.

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyrighted, 1957, by the Medical Association of Georgia, 875 West Peachtree Street, N.E., Atlanta 9, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; \$1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.

Journal OF THE
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ASPIRATION BIOPSY

This diagnostic aid has achieved wide acceptance in the management of cancer and other diseases. Techniques and applications are discussed.

JOHN T. GODWIN, Atlanta, Georgia

THE PURPOSE OF THIS article is to review the technique and application of aspiration biopsy since the original reports by Martin and Ellis^{49,50}, Ferguson²², Coley, Sharp and Ellis¹⁴, Sharp⁶⁴ and Stewart⁷⁰.

By aspiration biopsy is meant the withdrawal of cells or small bits of tissue through a needle by means of negative pressure. This would include bone-marrow aspiration. Needle biopsy of the liver is somewhat different from the usual aspiration biopsy in that a Silverman needle is employed that actually cuts away a small bit of tissue without the use of negative pressure. Because of ample reports on bone-marrow aspiration and liver needle biopsy, these procedures will not be discussed in this paper.

With the popularization of cytological diagnosis during the past few years, there has been increasing interest in aspiration biopsy, reflected by the numerous articles on the subject. The references listed in a recent report by Smetana⁶⁶ on this subject will serve to augment those given here.

In 1867, Lucke and Klebs⁴³ described malignant cells in smears of peritoneal fluid obtained by trocar in a case of carcinoma of the pancreas with metastasis to the omentum.

Bahrenburg² in 1896 reported his results after examining ascitic and pleural fluid from three patients. Greig and Gray²⁹ in 1904, performed aspiration of nodes in order to isolate the etiological agent of trypanosomiasis. White and Proscher⁷⁵ in 1907

recorded their unconfirmed observations of spirochetes in juice aspirated from lymph nodes in various diseases. In 1909, Horder²³ reported upon lung puncture for diagnosis. Ward⁷⁴ discussed node puncture in 1914 and suggested that the appearance of cells obtained by puncture of nodes might aid in the diagnosis of lymphoblastoma. In 1914, Chatard and Guthrie⁶ reported upon a case of trypanosomiasis diagnosed by node aspiration. Guthrie³⁰, in 1921, made a serious attempt to study cells obtained by aspiration from lymph nodes.

In 1922, Ellis²¹ recorded three cases of carcinoma diagnosed by examination of pleural fluid. In 1927, Dudgeon and Patrick¹⁹ recorded a study of 200 tumors examined by direct smears and, during the same year, Forkner^{25,26} reported upon a study of node aspirates.

Following this, around 1926, Dr. H. Martin⁴⁷, with the cooperation of Doctor F. W. Stewart and of E. B. Ellis of Memorial Hospital, New York, New York, began what has now become a rather routine procedure at this institution.

It is a procedure which has been found to be time-saving, efficient, relatively painless, safe, and inexpensive. It requires cooperation between the surgeon and the pathologist, and a knowledge on the clinician's part of what may be expected of the procedure. The interpretation of aspirates, as with other pathological material, is certainly not without pitfalls. It requires experience. It is necessary that a

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sufficient number of cases be available for both clinician and pathologist to maintain their efficiency. The pathologist must know the clinical setting, the normal cells of the region, and the nature of lesions to be anticipated in the area. Experience may be obtained by making smears from surgical and autopsy material or by doing aspirations without rendering reports until proficiency and confidence are obtained.

Since the late 1920's few reported complications have occurred through its use. There is no doubt that spread along the tract may occur; but in most instances, if the lesion proves to be malignant, the tract is excised when a breast, for instance, is removed, so that this danger is obviated. In the innumerable instances where the track remains, however, spread along it is so infrequent that documented material of such cases is nearly nonexistent. I have examined the material on one case reported by Crile and Hazard¹⁵. This was a papillary carcinoma of the thyroid in which a small tumor nodule developed in the needle track. Dolley and Jones¹⁸ have recorded extension along a thoracentesis track. Air embolism may occur as a complication of aspiration of the thorax.

Many cells are obtained in the average aspiration and, therefore, the diagnosis of aspirated material is not based upon three or four cells, but generally upon a large number. In the smears, the cells show loss of cohesion, large and hyperchromatic nuclei, cytoplasmic vacuolization, large nucleoli, and abnormal nuclear-cytoplasmic and nuclei-nucleoli ratios. Occasionally, more specific features, such as mucus secretion, may be evident. The clots are helpful in many instances where the smear is not diagnostic and in making a more definite diagnosis as

to the type of tumor.

Experience with the use of aspiration biopsy in a general hospital has demonstrated its applicability where there is an interest in the method by surgeon and pathologist.

Indications and Contraindications

The indications for the procedure have not changed since the original reports. They include: (1) any palpable tumor deep to the surface and covered by normal tissue; (2) a tumor where surgical biopsy is difficult or requires a major procedure; and (3) any deep-seated lesion.

The contraindications for aspiration are lesions that may be in proximity to such vital structures that damage might be serious, as about the large vessels of the mediastinum. Although large vessels and viscera have been punctured, serious consequences have not resulted. For a more extensive discussion of the advantages and limitations of aspiration biopsy, one is referred to an article on this subject by Martin and Stewart⁵¹.

Aspiration is employed principally in lesions of the breast, head, and neck regions, and of the bone, since lesions in these positions offer the most practical application of this procedure.

Technique

Many different needles and apparatus^{5,7,8,32,65} have been employed for aspiration and needle biopsy. The more simple ones, however, are still preferred. These consist of a record syringe (20 cc.) and 18-gauge needles of different lengths with obturators and rake (Figure 1).

The skin over the aspiration site is sterilized and incised with the end of a sharp No. 11 Bard Parker blade. The needle is inserted into the tumor while

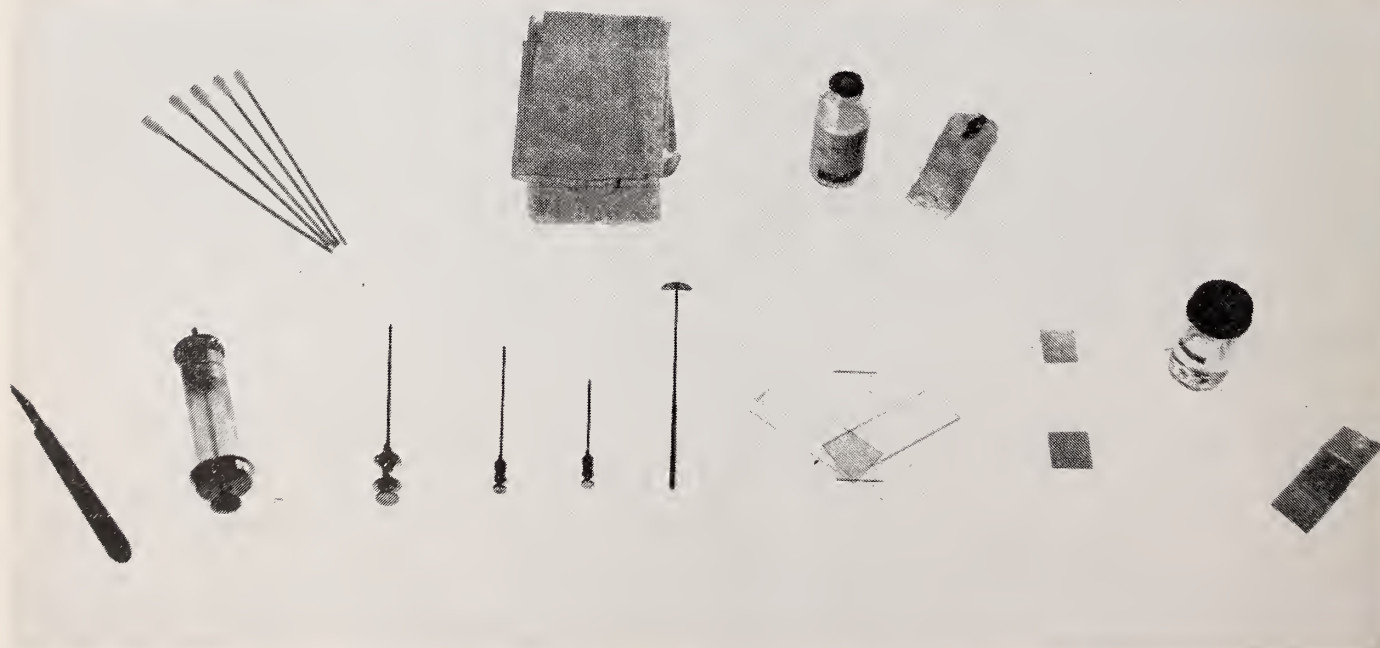


Figure 1: Various needles and other apparatus employed for aspiration and needle biopsy.

the tumor is steadied with the opposite hand (*Figure 2*). The obturator is removed and the syringe attached. The plunger is pulled as far out as possible, and the needle gently moved in different directions within the tumor in order to dislodge material (*Figure 3*). After the material is obtained in the syringe, the negative pressure is released to obviate splattering of the aspirate in the syringe. With the rake, the material is placed on several slides and gently smeared by approximating two slides and pulling them apart. The remaining material is placed on a small piece of blotting paper or fibrin foam and put in formalin for later paraffin section (*Figure 4*). This is designated as the clot.

The smears are allowed to air-dry. This has been found to give satisfactory results. A variety of fixatives have been tried, as well as alcohol-ether fixation while the smears are still wet, but this has not materially helped in diagnosis.

Fluid sediments may require albumin-coated slides. The smears are stained with hematoxylin and eosin. Clots are processed as any other biopsy.

The application of the procedure will be discussed in a regional fashion.

Cancer of the Breast

Cancer of the breast is one of the most suitable of neoplasms for aspiration. It is readily accessible and there are no major structures that might be damaged accidentally.

After a report of carcinoma, a radical mastectomy is performed, thereby obviating a local excision, lengthened anesthesia time, and redraping.

The cells from carcinoma of the breast generally show prominent variation in nuclear size with abnormal nuclear-cytoplasmic ratio, hyperchromasia, and large nucleoli. The cells are usually arranged in small clumps or singly, being less cohesive than normal, or noncancerous epithelium, such as the cells from a papilloma. Occasionally, an aspirate will be composed of smaller neoplastic cells somewhat resembling plasmocytes.

Smears are much more satisfactory for diagnosis than are the clots in breast aspirations. An occasional aspiration presents difficulties, and a report reading "atypical cells, require frozen section" is rendered. It is, of course, more sound to err on the side of safety if there is any doubt as to the diagnosis of cancer.

It would appear reasonable that an aspiration biopsy of a breast carcinoma would be less likely to disseminate cancer cells to the extent that an incisional or excisional biopsy would. The remote possibility of extension of the tumor along the needle track is of no practical concern, since the breast is removed following diagnosis or, if the lesion is not amenable to surgery, little harm would be done.



Figure 2: Aspirating needle is inserted into tumor.



Figure 3: Tumor being aspirated.



Figure 4: Smears being prepared from aspirated material.

The greater the experience with the procedure, the more useful it becomes. The essential point in aspiration biopsy is to differentiate benign from malignant lesions. Diagnosis by smears of the average carcinoma of the breast is generally an easy procedure after a little experience. There are instances in which the atypical cells are few or only slightly atypical. A situation such as this requires conservatism, since a few atypical epithelial cells may be seen in cystosarcoma phyllodes, papilloma, and sclerosing adenosis. When the diagnosis of carcinoma is made, there should not be any doubt that the diagnosis is correct. To compromise will lead to mastectomy for benign lesions. There is a level of cytological atypism, below which one may not safely diagnose carcinoma even though the percentage of error may be small. Any radical mastectomy for a benign lesion is too many for any series. The solution to this is experience with many smears. Papilloma may be suggested and diagnosed by smears when one obtains sheets of epithelial cells with uniform nuclei. Sheets of epithelial cells from fibroadenoma, cystosarcoma phyllodes, and cystic disease may simulate papilloma.

Papillary carcinoma may suggest papilloma superficially. The variation of nuclei in the former, however, will usually enable one to separate the two. Fibroadenoma may be diagnosed if fibrous fronds are found. The epithelial cells may be in sheets but are uniform.

Cystosarcoma may be diagnosed occasionally by the presence of fronds and atypical epithelial cells. Rarely, a malignant cystosarcoma may be diagnosed. Other lesions, such as malignant lymphoma, angiosarcoma, and liposarcoma may be diagnosed as a malignant tumor and, occasionally, the histogenesis of the lesion may be suggested.

Aspirates of cysts rarely contain malignant cells, usually only a few benign epithelial and red blood cells. Johnston³⁵ has recently reported upon the use of aspiration in cysts of the breasts as a therapeutic procedure. It has been similarly employed in the breast clinic for many years with good results. Occasionally cysts may contain large apocrine cells that may cause some diagnostic difficulty, but the cells are usually quite uniform and have a normal nuclear-cytoplasmic ratio. Aspirates from areas of fat necrosis contain macrophages, foreign body giant cells, and leucocytes. A few epithelial cells, usually with uniform nuclei, are encountered. One should be cautious in diagnosing carcinoma in the presence of inflammatory material, since atypical but benign cells may be encountered.

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Gynecomastia may be suggested by the presence

of sheets of benign epithelial cells. Mastitic aspirates will show many inflammatory cells.

Of 1,579 breast carcinomas seen in one five-year period, 806 aspirations were performed by experienced residents, and a correct diagnosis was obtained in 90.1 per cent. In the remainder (9.9 per cent), inadequate material was obtained for diagnosis. Of the 773 cases of breast carcinoma in which aspiration was performed by less experienced residents, there were 156 (20 per cent) failures¹. The incidence of false positive reports has been nearly nil.

Robbins et al⁶², in a recent study made to ascertain whether or not aspiration biopsy of breast cancer is dangerous to the patient, concluded that it seemed to have no effect on long-term survival rates. Kaae^{36,37} has employed trephine biopsy of breast lesions extensively.

Head and Neck

Lesions about the head and neck region, such as those in lymph nodes, salivary glands, antrum, and thyroid, readily lend themselves to aspiration. Enlarged lymph nodes in the presence of a carcinoma may be aspirated in order to plan the surgical procedure properly. A positive aspiration obviates surgical intervention in the neck, which might interfere later with a proper neck dissection. Aspirated material from nodes in metastatic carcinoma occasionally enables one to guess the primary site, such as thyroid, ovary, gut, and so on. Of numerous lesions occurring about the head and neck, many have been aspirated and diagnosed, such as carotid body tumors⁴⁶, neurilemoma²⁰, bronchogenic cysts, all types of salivary gland lesions⁴⁸, malignant lymphoma, actinomycosis, various thyroid lesions^{68,16,41}, antral lesions, metastatic carcinomas and others. Here again, it is necessary for one to know the site of the aspiration and what lesions may occur in that particular location.

Bone

The Bone Service, Memorial Hospital, New York City, routinely performs aspiration biopsies and reports about 80 per cent successful results^{4,67,13,31}. A review of 150 cases of multiple myeloma²⁷ at this institution revealed that 56 were diagnosed by aspiration biopsy, excluding sternal aspiration. Valls et al⁷³ have written a monograph on this subject. All types of bone lesions, except the more sclerosing types of osteogenic sarcoma, lend themselves to aspiration. Occasionally, differentiation between a metastatic and a primary lesion may be difficult. Also, differentiation among lesions such as Ewing's sarcoma, reticulum cell sarcoma, and metastatic neuroblastoma may not be possible nor, for that matter, may they be with sections. As always, an adequate history and a knowledge of the clinical features are of great help. Difficulty may certainly

arise, as in the giant cell and cartilaginous tumors since in large paraffin sections the diagnosis may be difficult.

Soft Parts

Tumors of soft parts include liposarcoma, malignant neurilemoma, rhabdomyosarcoma, fibrosarcoma⁵⁷, lipoma, and other mesenchymal lesions. Most frequently, the diagnosis of malignant tumors is about as far as one can go, although the clot occasionally helps to clarify the histogenesis.

Thorax, Lung, and Mediastinum

According to Pool⁶¹, the preferable lung lesion for aspiration is a discrete peripheral one. The procedure is indicated when five sputa or washings fail to reveal cancer cells and when exploratory thoracotomy is contraindicated by associated severe systemic disease, advanced age, or patient refusal, and there are no other sites available from which to establish the diagnosis. Emphysema is a contraindication, especially with blebs and bullae, because of the possibility of producing a tension pneumothorax. There is danger in aspirating lesions adjacent to major vessels, as in the apex near the subclavian vessels or at the pulmonary root.

The procedure is applicable in lesions of the posterior mediastinum, especially those in the gutter, when surgery is contraindicated or refused by the patient. The possibility of the presence of an anterior meningocele should be kept in mind, although aspiration would not be dangerous unless infection supervened.

Lesions of the anterior mediastinum suitable for aspiration are those in which the tumor is against the chest wall, and in which chest fluoroscopy and/or angiocardiology definitely show the lesion to be separate from the heart and aorta, also those lesions located away from the superior vena cava, either more lateral or inferior, on the right, and those that can be approached through the left anterior chest.

Ribs and vertebrae may be aspirated when one can keep away from the aorta.

The major complications are air embolisms, which can be prevented by positioning the patient with head down, and pneumothorax, either due to air being allowed inadvertently to enter through the aspirating needle or from puncture of blebs, bullae, or pneumatocele. Rarely have deaths been reported following aspiration of the thorax. Spread of tuberculous lesions, emphysema, or seeding of the pleura by cancer cells are theoretical possibilities, but have not been observed. Although no seeding of aspiration tracks has been observed, growth along a drainage tube and in thoracotomy scars have been seen rarely. Minor hemoptysis may occur.

Occasionally, when the lung is exposed at opera-

tion, the lesion may be aspirated for diagnosis before definite surgery is performed. Several authors have recorded their experience with aspiration biopsy of lung lesions^{3,10,11,12,28}.

Genitourinary

Whitmore⁷⁶ employs aspiration for renal, prostatic, and metastatic lesions. Usually aspiration of kidneys or prostatic tumors is performed when no attempt at operative excision is planned, but where pathologic diagnosis is needed.

Aspiration has not been employed in testicular tumors. Aspiration is most useful in establishing a pathologic diagnosis in cases of clinically advanced prostatic cancer. In a recent report by Kaufman et al³⁸, needle biopsy has been found useful in the diagnosis of early prostatic carcinoma. Clarke et al⁹ have reported one case in which an implant grew in the perineum 13 months following needle biopsy. Spring and Alden⁶⁹ have recorded their observations in a series of 83 cases in which needle biopsy was performed. Renal aspirations^{34,40,58} has been employed in studying various conditions of the kidney.

Lymphoma

The malignant lymphomas present difficulty in diagnosis in aspirated material, and, most often, a node excision is required. Of the various lymphomas, Hodgkin's disease and reticulum cell sarcoma are the more readily diagnosed. The lymphomas composed of small cells are not easily diagnosed on aspiration.

Morrison et al⁵⁶, Pavlovsky^{59,60}, Strunge⁷¹, Tempka and Kubiczek⁷², Dearing¹⁷, and others have used aspiration biopsy in the study of various lymph node lesions. Loeske⁴², in a small series of aspirations in Hodgkin's disease, obtained 56 per cent positive results.

Liver, Spleen, and Pancreas

Occasionally aspirations of the spleen are employed, and Gaucher's, Hodgkin's, and other diseases may be diagnosed. Splenic aspirations, however, are performed infrequently. Morrison et al⁵⁵ have reported upon their study of splenic aspiration. Moeschlin⁵³ has published a monograph on the subject, and Shapiro and Watson⁶³ have recorded their observations of splenic aspiration in multiple myeloma.

Aspiration of the liver as such is also infrequently performed. Ordinarily, the procedure employed is the standard liver needle biopsy with a Silverman needle. In view of the extensive reports on liver needle biopsy, no further comment will be made.

The spleen, liver, and other viscera, such as the pancreas³⁹, may be aspirated during operative procedures since this is a quick and easy way of obtaining a small amount of material without cutting into the lesion or organ before a definitive plan of operation is formulated. Mayo and Baskin⁵² have found

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needle biopsy useful in establishing the diagnosis of solitary liver nodules during abdominal surgery.

Miscellaneous

Aspiration biopsy may be performed in the central nervous system, and in reality many of the specimens received from the operating neurosurgeon amount to this since many times the minute specimens must be smeared³⁴ since sectioning is not possible. Smears from thoracic and abdominal fluids are frequently made but may offer much difficulty in interpretation because of the atypical appearance and arrangement of mesothelial cells. Foot^{23,24} and Luse and Reagan^{44,45} have recorded their observations on cytological studies of pleural fluids.

Summary and Conclusions

The technique and application of aspiration biopsy has been reviewed. The procedure has been found to be an aid in diagnosis and management of cancer and other diseases. It has not been found to affect the course of a disease unfavorably.

It is hoped that this brief report will stimulate those physicians in a suitable environment to employ the procedure in the diagnosis of neoplastic diseases.

272 Courtland St., N.E.

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COMMUNITY MENTAL HEALTH DEVELOPMENT

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FOR THE LAST TWO YEARS, it has been my privilege to be the Director of the New York City Community Mental Health Board. Established under an act passed by the Legislature in 1954, this Board has the responsibility for planning and coordinating the mental health services, except for specialized psychiatric hospitals, for the people, 8,000,000 of them, of the five counties of the state that make up the city, and has its counterparts in other counties in the state. These local boards are granted financial resources by the state in an amount equal to \$1.00 per capita of the population which may be used, with state approval, to match, dollar for dollar, local expenditures for mental health programs. The details of building up the necessary staff policies and organization to carry out the mission of the New York Board are very interesting, but they are not the subject of this paper.

Purpose of the Act

The matter for discussion here is the fact that this law signalized a return of responsibility for the care of mental patients to the local community, and the reasons that seem important first for the shift from local to state responsibility, and now at least a partial return to the older pattern. New York State and City will be referred to frequently, not because they are necessarily models for others to follow slavishly, but for the simple reason that it was work in those areas which stimulated the thinking about the problem.

The New York State Community Mental Health Services Act crystallizes into action certain theoretic developments in psychiatry of the last fifty years which have not previously been attacked directly or have been engulfed in the cultural lag between theory and practice.

The Act was not a mere statement of intent or purpose, but was intended to produce action. Like other states, New York had been stimulated better to face its extra-mural mental health problems by reason of the grants under the National Mental Health Act which began there, as here in Georgia, in 1947. The experience with these relatively small amounts of money served to demonstrate an enormously larger need than these funds could meet, and further served to show that it was extremely difficult to distribute the funds satisfactorily from the state

The author's extensive experience in New York City forms the background for his discussion of the vital responsibility of the local community in problems of mental health.

level. Furthermore, it had become rather clear over the years that the dual pattern for providing local services to the state that had become traditional was not likely ever to fill the needs of the local communities. The two patterns referred to are the establishment of clinics connected with the various state hospitals, and the establishment of a system of child guidance services organized at the state level and employing traveling teams.

Lack of Trained Personnel

The out-patient clinics connected with the hospitals were constantly embarrassed because the available personnel could not be freed of their essential, hospital-centered duties. The bulk of the work there did not allow these clinics to have available persons with the range of skills necessary; particularly difficult to maintain was skill in child psychiatry and in dealing with neurotic pathology when the basic work load of the personnel was almost completely with adult psychotic patients. The travelling child guidance clinics, developed at least partly to offset these difficulties, were found in many instances to be spread so thin that they could not approach meeting the obvious needs. They were also rather highly specialized and at best attempted to deal with the problems of the children in the community and did not aim at the "all purpose clinic" ideal.

One further factor appears to have been important: that the responsible authorities of the state recognized that the issue of community mental health transcended the range of interest of any one department of the state government. It was conceived that mental health was a permeating concept that refused to be confined. To do justice to this realization, the federal funds were administered by a Mental Health Commission made up of the heads of the departments of Mental Hygiene, Education, Social Welfare, Health and Corrections. This fact undoubtedly tended to spread the idea that a community mental

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health plan should not be controlled by a narrowly-conceived responsible body.

Thus, when the local Mental Health Board was designed under the Act, it was set up as an independent department of the local government but with the Commissioners of Health and Welfare as ex-officio members. The other members were to be representative of the community, with special care that the medical profession was well recognized.

There are those who doubted the necessity for this establishment of an independent governmental agency and who had more faith in the possibility that health departments might enlarge their scope to deal with mental health as a part of general health. There were many reasons for not acting upon this hope, not the least of which was that it was likely that in some parts of the state, local mental health organization would precede that of general health services.

The Community Mental Health Services Act of 1954 was not a mandatory, but a permissive Act. The fact that it had a provision to match all local expenditures up to \$1.00 per capita from state funds made the Act very attractive, particularly to communities already furnishing mental health services. The result was that 80 per cent of the population organized to make the Act effective within one year; the 50 per cent of the population living in New York City's five counties were involved almost before the ink was dry because of the savings to the city the Act made possible. The money freed by the state reimbursement could immediately be put into badly needed expansions and improvements of services.

History of Mental Health Care

In colonial America and until about the middle of the last century, the responsibility for all mental health care was that of local government. "All mental health care" did not, of course, include very much more than the custody of the mentally ill and the protection of the public from the "insane." The highest ideal of treatment was the essentially passive, "moral" treatment, the basic ideal of which was that kind treatment in a friendly atmosphere would result in a higher proportion of recoveries than unkind treatment in less friendly atmospheres. This ideal was reached in a very small proportion of asylums; most were unhealthy, cruelty was common, and classification of the ill was impossible under the architectural conditions. The plight of the mentally ill became so deplorable that it called forth the reform movement led by Dorothea Dix. Her primary plea was directed to the states. She was able to badger, persuade and lead many of them to accept most or all responsibility for psychiatric patients. In general, the mentally ill became wards of the state. This

happened in 1890 in New York State and resulted in great improvement in "the condition of the insane" as Miss Dix put it.

Had psychiatric theory of the etiology of the mental diseases remained constant, and had no new treatments been discovered, the building of more and better state hospitals furnishing more kindly custodial care would have remained a justifiable ideal. But psychiatry was not to remain constant either in theory of cause or in method of treatment.

Psychodynamic Theory

The disturbing factor, of course, was the development of psychodynamic theory and its consequence, psychotherapy. I do not mean to disparage the great advances in organic types of therapy; these are not, however, essentially new in the last century, but are developments of ideas which have been influential for a far longer period. They are at this very moment reaching new highs with the advances in biochemistry, particularly that of enzyme chemistry and physiology. There would appear again to be hope for chemical differentiation of some of the symptom complexes, and new possibilities for the development of specific rather than empiric types of direct physiological treatment.

Psychodynamic theory first was the largely intrapersonal concept of Freud, concerned primarily with the individual and the small family group, extended to be sure, to include some others through the mechanism of identification. Freud stimulated the development of anthropology, but this did not achieve a level of concept that could lead to the possibility of changing the culture for the sake of modifying vulnerability to disease. The techniques of psychoanalysis were early standardized to exclude other members of the family and the larger social groups from influencing the intensive one-to-one relationship of patient and analyst. It is doubtful that social work could have developed as it has in psychiatry had not others diluted the Freudian method of work.

Meyer, for example, was not satisfied with what the patient could tell; he sought much wider sources for his information, both to interpret the patient's interpersonal relationships outside the therapeutic setting and to interpret the cultural patterns which were, presumably, effective in the formation of the personality. It was this seeking for information which led to the development of the professions that help the psychiatrist, bringing to him information without the warping of the patient's prejudices and testing the patient's sense of reality. The aims of these professions have changed considerably since they were established, of course, but they were established for the purpose of enlarging the psychiatrist's grasp of the personal and cultural environment of the patient before him. The reason such facts were necessary

was that they were believed to be important in understanding the cause of disease and planning its treatment.

This need could not be met at all easily from the level of state hospitalization. The hospitals were distant from the local community where the patients lived. They were understaffed and over-burdened with custodial problems. In many instances, they became isolated from the stream of the practice of medicine. They were not in a position to respond to the new development of psychodynamic psychiatry. This is not to say that they did not, are not responding to the challenges. In New York State there were out-patient clinics based on the state hospitals as early as 1908, and other states followed suit fairly rapidly. In both Massachusetts and New York, the hospital based clinics proved not to be able to meet the total need, particularly the specialized needs of children, and the result was the building of a separate out-patient service of travelling teams to satisfy this need.

These services tended to become quite separate from the hospital. Often, they did not grow into their communities very deeply. This was partly because they could not come often enough to become thoroughly acquainted and acculturated. The conclusion gradually was reached that a new system of supplying local services would have to be evolved if localities were to be served adequately and with services based on recognition of cultural and sociologic considerations.

There were partial models available for the new system. The 1920's and earlier had seen the establishment of receiving hospitals, then known as psychopathic hospitals, with the aim of furnishing acute, short-term treatment where it was practicable. In some instances, such as in New York City, these were locally supported institutions, in others they were "out-posts" of the state hospital system serving local communities. The child guidance clinic movement had shown the advantages of clinics integrated with schools and social agencies in the local community. For the most part, these clinics were supported in the beginning by voluntarily contributed funds, though some received subsidy from courts, schools, and other tax-dependent agencies. In other words, there had been a spontaneously growing dilution of the idea that mental health services were a state responsibility and a realization that locally based services were necessary in dynamically oriented psychiatry.

Problem of Finance

The problem of finance was, however, no better than it was before 1840. The smaller units of government were still bereft of the taxing powers that had made state financing necessary to improve treat-

ment. It was clear that if localities were to improve and expand their services, a method of joint state and local tax financing would be required. This was furnished in the Act by the provision already mentioned that if a locality furnished services costing up to \$2.00 per capita, the state would reimburse one-half of the expenditure. In passing, I should perhaps note that expenditures in New York City for 1957-58 fiscal year will probably exceed \$2.25 per capita. All mental health services at the local level, excluding only state psychiatric hospitalization and hospitalization in special psychiatric hospitals, are included under the Act. The pendulum has swung and the care of psychiatric patients other than the chronic has become the responsibility of the local government.

Basis for New Outlook on Mental Health

The over-all theoretic basis for this change has been indicated already, but perhaps it is justifiable to pursue the matter further in detail. First, the issues of the influence of sociology and anthropology in forcing the return of responsibility to the smaller governmental unit. The essence of the sociological influence of psychiatry is that there exist different social groups and classes in a culture and that the differences which exist make a difference in the behavior and attitudes of the group. By extension to psychiatry, the assumption is made that the differences post different psychological stresses upon the individuals in one group or class from those on another group or class and that, therefore, different rates of disease will be found in these groups or classes. Furthermore, it can be shown that this is actually the case with many infections and other types of diseases, such as the nutritional ones, which increase vulnerability to the mental diseases and behavior disorders.

Preventive activity, designed from the sociological point of view, is for the purpose of reducing all the rates to those of the group producing the least disease, on the assumption that the low rate is associated causally with the conditions of living in that group. The unsolved problem is to determine which of the variant factors in each of the two groups are significant etiologically.

The scope of probably useful empiric sociological knowledge is growing rapidly. Already available are many facts concerning differences in attitudes toward marriage and child rearing, for example. The incomplete publication of the Starr and other studies on the variation of public attitudes toward psychiatric disease and resources for its treatment by socio-economic class are likely to reveal greater diversity along these lines than we are presently aware of. The ambivalence existing in this area of attitudes, also revealed in Starr's early statements, indicates the sort

of resistive forces one is likely to meet along with the socio-economic class specificity of attitude.

It is clear that if there is to be real meaning in the use of sociological concepts in the understanding of psychiatric diseases and in their treatment, services must be based on an understanding of the social class and group from which the patient comes. The extent of the knowledge necessary to reach such understanding is immense; it is unlikely that it can be learned for all groups in a culture; it is likely that the extent of what is to be learned will dictate local planning for mental health services even beyond what we now conceive of as a local planning unit; under the mental health act, it is the county or city.

Cultural anthropology is not dissimilar to its effect on planning though it might be said that the factors dealt with in the science are less fixed by immediate circumstances but are more rigid because of traditional folk lore and religious patterns and more deeply integrated in the personality structure of the people. By the same token, it might be assumed that personality disorganization might be more serious when cultural patterns are to be changed than when sociological class changes take place; of course, the two are actually inseparable.

Anthropological data, while generally of larger scope and coverage than sociological, nevertheless dictate that wherever different cultures come into contact with the pressure to merge, the effects will probably be seen in personality and behavior disturbances. This hypothesis is one of the many being treated by Leighton in his extensive Sterling County studies. The contact area between the French-Canadian and the English-Canadian cultures is apparently rather small. If psychiatric study and treatment is to plan to take inter-cultural and intra-cultural factors into account, it will have to be undertaken at a distinctly local level.

It is obvious that there is a very great deal of research and experimentation to be done to test the hypotheses concerning the direct and indirect influence of cultural and sociological factors in treatment. It will be sufficient to point to the enormous literature on inter-class communication and on the problems of formal thought and linguistics; time will not permit following up the detail in these areas. It does appear that the work cannot be planned at a distance from the essential problems; it must be done locally.

Early treatment has a special, practical application in psychiatry of which those of us with military combat experience are very aware. It has reached the security of a cliché: "treatment within the sound of the guns."

I suppose no one any longer has much confidence

in the exactness of figures of returns to duty from the various installations at different distances from the front, but the general concept remains valid. It has been suggested frequently that one reason forward treatment is generally more successful than that done in rear areas is because the treating psychiatrist is more acutely aware of the type of stress undergone than a rear echelon psychiatrist. This bolsters the idea that in civilian life also, treatment close to the place of onset is most desirable, and it lends support to local planning for services.

Industrial psychiatry also appears to be coming to the conclusion, on clinical grounds, that treatment is most successful when the patient remains on the job and is not relieved of too many of his usual responsibilities for too long a time. By extension, this concept would lead to the conclusion that the housewife should have the opportunity to be treated without interruption of her work, and the school child while continuing his studies and by people who know intimately the way these people actually live in their homes and in their schools.

Psychodynamic psychiatry demands family oriented treatment, treatment that takes into full consideration the fundamental relationships with which Freud was primarily concerned. The implications for locally oriented treatment are so obvious that they need not be further enlarged upon. Certainly, local services planned with clear understanding of family patterns and within the range of easy travel are indicated and required.

Educational Preventive Field

Mental health services discussed thus far are those addressed to the sick. There are more challenging, less clearly defined services to be done in the educational preventive field.

The problems of evaluation in this field are tremendous and tend to retard the program on what are essentially sound, ethical grounds. A therapeutically intended service requires less evaluation to justify it because its essential aim is to relieve distress that is complained about by the patient or the community. If it is an honest attempt to relieve pain, it is already justified ethically even though scientifically its justification leaves much to be desired. Preventive efforts, however, are not primarily designed to relieve present pain but some future painful stress that is predicted will be less painful if prepared for, and therefore, less damaging to personality structure. It implies an invasion of the privacy of people for a purpose which is probably good, and is believed to be actually preventive by the person doing it but may prove not to have been so in the long run. Scientific justification is really needed to make the invasion of privacy ethical from the medical point of view. The issue of evaluation becomes of the very essence of

preventive work in the psychodynamic area.

Such evaluation must, of course, be done at a local level, in very close contact with the groups being influenced. Even statistical evaluations must be designed with this in mind as is indicated in the school studies of Balser and others. As an illustration of how extreme the localization must be, I cite a study which fortuitously brought a small number of people who had taken part in a carefully planned series of workshop educational experiences into psychoanalysis with the psychiatrist ultimately responsible for the program. The analyst reports that comparison of patients from the workshop with similar patients who had not had that experience showed the treatment to be more efficient and quicker in effect in the workshop group because they were prepared for discussion of some important areas in the analysis. While such evaluations cannot have the force of statistical evidence, they can certainly offer an excellent base for the eventual design of definitive tests. The need for local coordination in such an experimental situation is indeed obvious.

The same line of thinking is applicable to the problem of preventing organic damage to the brain by whatever cause. When action of any sort is to be induced, attitudes must be changed. The forces in development of attitudes are likely to be local in character, based on culture and social class. As has been discussed elsewhere, the recognition of this fact has greatly influenced the whole field of health education, to say nothing of the retail trade where "se habla español" in the window of a store indicates adaptation of the trade to local linguistic patterns.

One final point and we are finished with this elaboration of the theoretical and practical reasons for expanding local responsibility for mental health services. This has to do with rehabilitation of patients returning to the community from psychiatric treatment, a type of program in which the Health Department of Georgia is leading the nation.

As already noted, various cultural and social groups react quite differently from each other regarding behavior pathology. Behavior intolerable to a class used to managing relationships in a drawing room may be quite tolerable in a group dealing with it mainly at the bar. Table behavior quite intolerable in a middle class family that eats together may not be a problem at all in a family group that habitually

eats, as many do, "on the run." The same goes for neatness of clothing, communication patterns and countless other human attitudes. The fitting of the patient into his own comfortable niche will or should certainly involve knowledge and adaptation to distinctly local sociological and cultural situations.

If clinical services are to be cognizant of the range of factors just outlined, and my thesis is that they must be to provide maximum efficient service, there must be someone to see to it that all have the opportunity to receive service. In general, psychiatry has been so pressed to take care of increasingly heavy demands for service that it has set too few personnel aside to keep an eye on coverage of the population and on efficiency of service. Immediate service responsibility often crowds out planning responsibility when the two are combined.

In New York State the local Community Mental Health Board is assigned the role of observer, coordinator, administrative researcher, with the aim of seeing to it that all have an equal chance for service in accordance with their needs. Whether or not this organizational pattern is suitable for other localities is unknown and is certainly not recommended without careful study taking into consideration local conditions. It is, however, in my estimation, a genuine attempt to test the hypotheses regarding the importance of culture and social groups in the prediction of stress on the individual and his adaptation to stress which may or may not result in breakdown with one or another form of mental disease. It is a "practical" attempt to put this type of psychodynamic theory into practice in treatment and in the rehabilitation of patients who have been severely ill. It recognizes in an administrative structure that psychiatric theory has made great advances since the mid-nineteenth century when local governments gladly surrendered their mental health responsibilities as then conceived to the state. The structure recognizes the financial interest the state must take if local governments are not to fall into the "slough of despond" regarding services from which Miss Dix heroically lifted them about 1850. It recognizes that the psychiatric hospital is but one unit in what must be a larger program of mental health promotion and that much of the program must be based on the thorough understanding of the locality to be served.

93 Worth Street

FROM SOCIAL SECURITY TO SOCIALIZED MEDICINE?

SINCE BISMARCK INTRODUCED socialized medicine in Germany three quarters of a century ago, the threat of socialized medicine through the extension of so-called social insurance has been ever-present in Western civilization. One nation after another has succumbed to the drive to extend the compulsory system of taxation called social insurance to finance a vast program of medical and hospital care for taxpayers and nontaxpayers. The history of developments in this field in foreign countries should alert the medical profession to the usual consequence of federal social security program.

RECOMMENDATIONS FOR THE G.P. DOING SURGERY

Some of the problems encountered in the field of abdominal surgery are outlined. The author makes recommendations from the standpoint of the major symptomatology.

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WHILE IT IS MY FIRM conviction that major surgical procedures should be carried out whenever possible by a qualified surgeon, it is true that in many communities general surgery, particularly of the emergency and traumatic type, must be and is done very well by the general practitioner. As a matter of fact, I have known several general practitioners whose work compared favorably with the best of the qualified surgeons.

However, the general practitioner doing general surgery is not infrequently handicapped by limited assistance, unsatisfactory surgical illumination and a lack of many of the ancillary needs that are considered essential to surgery today. Fortunately, the great majority of general practitioners have a clear notion of these limitations and avoid procedures which they consider beyond their own limitations or the limitations imposed by the facilities that are available.

Since abdominal surgery is the field in which the general practitioner is most often engaged, I propose to review some of the problems to be encountered in this field. Since many of the pitfalls in surgery relate to diagnosis as well as surgical treatment, it is appropriate I think to present my recommendations from the standpoint of the major symptomatology. It is to be pointed out that this discussion of these symptoms of intra-abdominal disease is by no means complete, consisting only of points that to me seem worthy of particular mention.

Massive Gastrointestinal Hemorrhage

Hemorrhage from the gastrointestinal tract is a common indication for surgical intervention and poses one of the most difficult problems in both diagnosis and treatment.

1. *Hematemesis*: While massive hematemesis may rarely result from such unusual lesions as Mallory-Weiss syndrome, gastric polyps, and carcinoma of the stomach, its occurrence should immediately suggest (a) either bleeding esophageal varices, or

(b) bleeding peptic ulcer.

a. *Bleeding esophageal varices*: In the great majority of cases esophageal varices result from portal cirrhosis, and examination of the patient will usually reveal clinical evidence of this latter disease. Spider angiomas of the chest wall, palmar erythema, a palpably firm or nodular liver, ascites, and jaundice are among the most conspicuous findings, and a history of excessive intake of alcohol is usually elicited. The immediate treatment of bleeding esophageal varices consists in the insertion of the double-balloon Sangstecken-Blakemore bag. It is our practice to inflate only the gastric balloon and impinge it into the esophagogastric junction by attaching to the nasogastric tube a one pound weight. Seldom does the patient tolerate this for more than 48 hours, and, in our experience, a recurrence of the bleeding after deflating or removing the bag takes place in the majority of cases. Consequently, transportation of the patient to a facility where an emergency portocaval or splenorenal shunt may be carried out should be seriously considered immediately on controlling the hemorrhage. The poor results and high mortality in such emergency shunts has prompted me to recommend a shunting operation in the patient in whom large esophageal varices are demonstrable in spite of the fact that hemorrhage has not occurred.

b. *Bleeding peptic ulcer*. Inasmuch as a clear clinical history suggesting the presence of a peptic ulcer is lacking in many such cases, the absence of evidences of cirrhosis should suggest this diagnosis. Since it is extremely important to distinguish between bleeding from a gastric and a duodenal ulcer, recourse to barium examination soon after admission to the hospital is advisable. The demonstration of a gastric ulcer is a clear indication for surgical intervention immediately after adequate blood replacement. The insertion of a nasogastric tube is recommended in every case in order to obtain information regarding continued bleeding and also to

preclude the development of gastric dilatation which lends shock to an already shocked patient.

The usual criteria for surgical intervention in a bleeding duodenal ulcer include failure of the blood pressure, pulse and general appearance of the patient to improve after the replacement of four to five units of blood, when there is evidence of continued bleeding after such replacement and recurrence of bleeding after the patient has been stabilized. In individuals under forty years of age these criteria do not always apply.

Resection of the stomach by one of the conventional means is the operation of choice in such cases. This resection should include removal of the ulcer in the first portion of the duodenum in all but the rare case where technical considerations preclude this. However, in these instances a transfixion suture should be placed in the bed of the bleeding lesion. Not infrequently the operator will be unable to demonstrate an ulcer in either the stomach or duodenum and is, of course, reluctant to resect the stomach under these conditions. However, in the presence of hematemesis without evidence of cirrhosis of the liver, gastric resection should be carried out.

2. *Melena*: Massive gastrointestinal hemorrhage manifested by bright red or tarry stools poses a much more difficult diagnostic problem than in the case in which the blood is vomited. In cases of melena the bleeding may have originated in any part of the gastrointestinal tract, and the character of the blood in the feces offers no dependable evidence of its site of origin, i.e. bright red blood in the feces may be present in the case of bleeding duodenal ulcer, and tarry stools may have resulted from a polyp in the colon. In such cases the aspiration of blood after insertion of the nasogastric tube provides invaluable information. Proctosigmoidoscopy after preparation with cleansing enemas should be carried out as the bleeding lesion may be in the distal sigmoid or rectum.

While the criteria for surgical intervention in these cases differ in no essential way from those employed in massive hematemesis, the incision should be so placed that the operator is able to carry out a thorough exploration of the many possible sites of bleeding. Distally located lesions that may provoke massive hemorrhage include Meckel's diverticulum with ectopic gastric mucosa, multiple polyposis of the colon, diverticulosis or diverticulitis of the sigmoid and occasionally a large polypoid cancer of the colon.

Not infrequently no demonstrable lesion is found after such thorough exploration, and the operator is forced to close the abdomen after a fruitless laparotomy. Certainly gastric resection based on the assumption that the bleeding has originated in an occult ulcer is to be avoided.

Acute Upper Abdominal Pain

The development of this symptom provides the basis for many emergency operative procedures. One of three conditions is usually responsible, namely (a) perforated ulcer, (b) acute cholecystitis, and (c) acute pancreatitis.

a. *Perforated peptic ulcer*: The character of the pain and the abdominal findings associated with a perforated ulcer usually make the diagnosis quite obvious. However, the absence of an ulcer history and the failure to demonstrate pneumoperitoneum with an upright x-ray film of the abdomen, and a mild elevation of the serum amylase may create doubt about the diagnosis. Nevertheless, a reasonable conviction that such a perforation has occurred should lead to immediate surgical intervention with closure of the perforation with silk sutures reinforced with an omental tab. The rare occurrence of a perforated gastric ulcer requires gastric resection.

While the nonsurgical treatment of perforated peptic ulcer employing a nasogastric tube to which continuous suction is applied is not recommended as routine therapy, it serves a useful purpose in those cases in which the weight of clinical evidence is against this diagnosis and in those cases in which the perforation has occurred thirty-six hours or more previously, in which cases evidence of generalized peritonitis is evident.

b. *Acute cholecystitis*: Acute inflammation of the gallbladder almost invariably occurs in a stone-containing organ. Consequently the knowledge of the existence of gallstones is helpful in making the diagnosis. As a rule, localization of pain with muscle resistance and later the appearance of a palpable mass in the right upper quadrant exposes the correct diagnosis. While there are proponents of early surgical intervention in acute cholecystitis, it is our practice to introduce proper antibiotic therapy and insert a nasogastric tube with suction on admission. During a period of 12-24 hours of observation, regression of the local and systemic signs leads to continued conservatism, while aggravation of the clinical evidences of cholecystitis requires surgical intervention. It should be pointed out that cholecystostomy together with disengagement of the impacted stone is a very satisfactory operation, and certainly the preferred one when facilities are at all limited. The development of jaundice in association with acute cholecystitis is in most instances not due to calculous obstruction of the common bile duct and will subside on regression of the acute cholecystitis.

c. *Acute pancreatitis*: The diagnosis of this condition is frequently difficult and unless one routinely obtains a serum amylase determination in cases of acute upper abdominal pain regardless of the localization, many of these cases will go unrecognized. In

the majority the disease process is one of edema (acute edematous pancreatitis), a self-limited condition which subsides in four to five days. In approximately 10 per cent of cases acute necrotic pancreatitis develops and is associated with shock, a falling hematocrit and the death of the patient in a majority of cases. In the edematous form of the disease there are two practical points of therapy. In the first place, the patient should be urged to abstain from alcoholics for months or years, and secondly a cholecystogram should be obtained approximately six weeks after the subsidence of the acute attack. On demonstration of calculous disease of the gallbladder, cholecystectomy is strongly recommended.

Surgical intervention has no role in the treatment of acute pancreatitis. In the event that the diagnosis is first identified at the time of laparotomy, closure of the abdomen without further operative manipulation is recommended. The development of a palpable mass in the upper abdomen after an attack of acute pancreatitis points to the presence of a pseudocyst or peripancreatic collection, surgical drainage of which is indicated in most cases.

Jaundice

The diagnosis of surgical jaundice is usually based on both clinical and laboratory evidences. Of clinical significance is the presence of colicky pain, acholic stools, dark urine and perhaps a history of gallstones. Laboratory evidence includes relatively unaffected liver function tests, high direct van den Bergh reaction, absent or diminished urobilin in the urine and feces, and elevated alkaline phosphatase. In cases where the clinical and laboratory findings are in conflict, it is a wise policy to place greater credence on the clinical features of the case.

Surgical intervention in *non-surgical jaundice* may be disastrous. Because of the presence of parenchymatous liver disease, these patients withstand anesthesia and operative trauma very poorly. It is to be borne in mind that both thorazine and methyl testosterone may provoke jaundice that is easily mistaken for the obstructive type.

On accepting the diagnosis of surgical jaundice, consideration must be given as to whether the obstruction is malignant or non-malignant.

Cancer of the head of the pancreas is clinically indistinguishable from cancer of the ampulla of Vater and of the common bile duct. An unremitting, progressively increasing jaundice with a palpably distended gallbladder is convincing evidence of this lesion. While there is some doubt as to the rationale of radical surgical attack on cancer of the pancreas, lesions of the common bile duct and ampulla lend themselves to surgical extirpation. And for this rea-

son, a simple tube-cholecystostomy, carried out at times under local anesthesia, relieves the distended biliary tree, and better prepares the patient for subsequent radical surgery.

Non-malignant obstruction is in most instances due to calculi in the common bile duct. However, a history of previous cholecystectomy or common duct exploration should suggest the presence of a stricture. And in the presence of recurring pancreatitis the jaundice may be due to compression of the retro-pancreatic portion of the duct. The use of cholegraphin, an intravenously administered dye, is most helpful in demonstrating common duct stones if the jaundice is not pronounced. In calculous obstruction the jaundice typically is remitting and incomplete. Recently the diagnostic value of a slight elevation of the serum bilirubin with an elevation of the alkaline phosphatase has been noted in cases of common duct stone.

Intestinal Obstruction

The distinction between high and low intestinal obstruction is usually not difficult. In the former, vomiting is the outstanding clinical feature with an absence of distention. A chronic cicatrizing duodenal ulcer is the most common etiologic basis for this type of obstruction in the adult. In low intestinal obstruction the degree of abdominal distention depends on the level of obstruction, being greatest when the obstructed site is in the left colon. The value of the scout film of the abdomen in these cases is great, often permitting identification of the type of obstruction, as in volvulus, intussusception or gallstone ileus. More importantly, the flat plate provides information as to the approximate level of obstruction, and often reveals the presence of a closed loop.

The determination of whether the obstruction is paralytic or mechanical is all-important. Auscultation of the abdomen with a stethoscope with a proper interpretation of these findings is most helpful in this regard. Absent or diminished peristaltic activity should suggest a paralytic basis, an impression that may be strengthened by evidence of intraperitoneal inflammation. Increased peristaltic activity, with peristaltic rushes, indicates the presence of a mechanical obstruction. On encountering evidence of a mechanical obstruction distinction between the simple type and the type in which there is compromise of the blood supply must be promptly made. In the treatment of the former, nasogastric suction is employed, permitting deliberate and careful correction of fluid and electrolytic imbalance. After several days the suction may be interrupted in an effort to permit spontaneous relief of the obstruction. Surgical intervention is resorted to only when a recurrence of the obstructive symptoms occurs on discontinuing suction. In the compromised type, however, early and

SOUTHERN MEDICAL ASSOCIATION MEETING

THE LARGEST MEETING IN 51 years of the history of the Southern Medical Association was held in Miami Beach, November 11-14. The unofficial registration total was 5,761, of which 3,133 were physicians.

At the conclusion of the meeting W. Kelly West of Oklahoma City, Oklahoma, was installed as President succeeding J. P. Culpepper, Jr., Hattiesburg, Mississippi. Other officers elected at this meeting were: President-Elect, Milford O. Rouse, Dallas, Texas; First Vice-President, Edwin H. Lawson, New Orleans, La.; Second Vice-President, Donald F. Marion, Miami, Florida.

Elections by the Council included Chairman, Fount Richardson, Fayetteville, Arkansas; Council Vice-Chairman, Harry Lee Claud, Washington, D.

C.; Member of Board of Trustees, J. P. Culpepper, Jr., Hattiesburg, Mississippi.

Recipient of the Association's Research Medal was Joseph M. Hill of Dallas, Texas. Dr. Hill is the sixteenth winner of this outstanding award for scientific research which was established in 1912.

Kenneth M. Lynch, President and Dean of the Faculty of the Medical College of South Carolina, received the Association's Distinguished Service Award.

The schedule for future SMA meetings is as follows:

1958—New Orleans, Louisiana, November 3-6

1959—Atlanta, Georgia, November 9-12

1960—Baltimore, Maryland, November 14-17

1961—Dallas, Texas, November 13-16

1962—Miami Beach, Florida

prompt surgical intervention is essential. Examples of this type include internal strangulation, intussusception, volvulus, and closed loop obstruction. Physical findings suggesting vascular impairment of the bowel include localized tenderness, palpation of a mass, tachycardia, and hypotension.

Acute Lower Abdominal Pain

It is undoubtedly true that the diagnostic possibilities and pitfalls are greater in cases of lower abdominal pain than when the pain is in the upper abdomen.

1. *Appendicitis*: It goes without saying that pain in the right lower abdomen must be considered the result of acute appendicitis until proven otherwise. The more one sees of the vagaries of this disease, the less reluctant one is to intervene surgically in a questionable case. Attempts at differentiating acute mesenteric adenitis, acute regional enteritis, and other uncommon lesions from appendicitis subject the patient to unwarranted delay. On identification of acute or subacute regional enteritis at the time of laparotomy, the appendix should not be removed unless definitely inflamed. Routine inspection of the terminal two feet of ileum for a Meckel's diverticulum should be carried out except in cases associated with local peritonitis.

2. *Diverticulitis*: Acute perforated diverticulitis is a serious surgical lesion. Although usually manifested by left lower quadrant pain, the anatomic disposition of the loop of sigmoid to the right may produce a

clinical picture suggesting appendicitis. Although acute diverticulitis should be treated conservatively, evidence of spreading peritonitis calls for prompt surgical intervention in all but the exceptional case. A transverse colostomy, diverting the fecal stream from the inflamed bowel, is the operation of choice.

3. *Surgical Diseases of the Female Internal Genitalia*: While these conditions are not within the scope of this paper, it should be pointed out that occasionally a twisted ovarian cyst, ectopic pregnancy or acute salpingitis may, under a mistaken diagnosis, lead to laparotomy. The operator who presumes to enter the abdomen for any reason should be equipped to deal with these gynecologic problems.

4. *Early Cancer of the Colon*: Occasionally a very early lesion, particularly of the left colon, will so interfere with peristaltic activity that the patient will complain of crampy lower abdominal pain. A lesion identified at this time is usually operable and carries with it an excellent prognosis.

5. *Fecal Impaction*: In the elderly or debilitated, lower abdominal pain may be caused by a fecal impaction, the identification of which will be made only by digital examination of the rectum, which should of course be a part of the examination of any patient complaining of abdominal symptomatology.

6. *Incarcerated Hernia*: It is astounding how frequently in a patient with lower abdominal pain an incarcerated hernia is overlooked. This is particularly true of a femoral hernia in the female.

1150 Connecticut Avenue

ELECTIVE CARDIAC ARREST

A report on the use of elective cardiac arrest in conjunction with a pump oxygenator in the repair of cardiac abnormalities in seventy-five patients.

DONALD B. EFFLER, Cleveland 6, Ohio

INTRACARDIAC OPERATION is more easily performed when the heart is arrested and restarted at the surgeon's will. In the quiet dry heart, visualization is excellent, a precise technical procedure is possible, and air embolus is not a major threat. Cardiac arrest as an adjunct to open-heart surgery is rapidly becoming common practice in major institutions throughout the country.

In July of 1955 Melrose and associates¹ reported results of an experimental technique of inducing cardiac arrest for open-heart surgery. The concept of their work was based on the well-known observations of Ringer,² who in 1883 published observations on the paralyzing effect of potassium upon the myocardium. In February of 1956 the author for the first time employed the Melrose technique in the surgical closure of an intraventricular septal defect in a 17-month-old child.³ This child is believed to be the first patient to have had a septal defect closed while the heart was deliberately stopped. Since that time, elective cardiac arrest and a form of pump oxygenator have been utilized for repair of cardiac abnormalities in 75 patients operated upon at the Cleveland Clinic Hospital.

Technique

Open-heart surgery employing the bypass technique requires an effective pump oxygenator. With this machine the venous system return to the heart is detoured to the oxygenator and then is returned to the arterial system in an oxygenated state. Although the majority of the blood flow is diverted from the heart, nevertheless a significant amount does return from the root of the aorta through the coronary circulation to the right auricle. Heretofore, conventional open-heart surgery, which employs only the pump oxygenator, has been performed while the heart is beating and a significant amount of blood is lost from the coronary return. Now, the ideal method of open-heart surgery is approached (one

that affords a dry field, a motionless heart, little blood loss) by the simple addition of the Melrose technique to the conventional bypass method.

After the patient is on the pump oxygenator "run" and the perfusion has become well stabilized, the heart is ready to be arrested. This is accomplished by occluding the aorta with an arterial clamp at the previously elected site. Then potassium citrate blood mixture* is injected into the base of the aorta. This material under pressure from the injecting syringe perfuses the entire coronary circulation and induces complete asystole within several seconds. The heart will begin to slow down and seemingly dilate as its myocardial fibers relax. The amount of potassium citrate mixture that is necessary will vary with the size of the patient's heart; in children as little as eight cc. may suffice, whereas in adults with cardiomegaly as much as 190 cc. has been necessary. The dose of potassium citrate is that amount required to induce total cardiac asystole.

Each or all of the four major chambers may be entered as the surgical indications direct. The dilated heart contains blood that may be quickly removed by surgical aspirator, and direct visualization in a quiet field is then made possible. There always will be a small blood flow to the left side of the heart from the bronchial vessels and any collateral vessels that might be present. After inspection of the internal cardiac abnormality, a precise unhurried surgical procedure may be undertaken.

Restarting the arrested heart is as simple as the induction of arrest. When the defect has been corrected the surgeon removes the occluding aortic clamp and the high pressure within the distal aortic arch allows prompt coronary perfusion. This perfusion washes the residual potassium citrate from the coronary bed, and the heart spontaneously resumes its beat. Under conditions of satisfactory

*We use two cc. of a 25 per cent solution of potassium citrate mixed with 18 cc. of heparinized blood. The heparinized blood is taken from the pump reservoir. For children one syringe containing 20 cc. of the blood mixture will suffice; for adults we have several syringes available for rapid injection, as the mixture is easily prepared by the surgical nurse.

From the Department of Thoracic Surgery, The Cleveland Clinic Foundation, and The Frank E. Bunts Educational Institute, Cleveland, Ohio.

perfusion the heart beat will return within several minutes, and, in the average case, the patient's heart can maintain a satisfactory circulation within five minutes after it has been restarted. The bond between the paralyzed muscle fiber and the potassium citrate solution is indeed a tenuous one, and is easily broken by the simple mechanical flow of the coronary perfusion.

Discussion

The time factor for safe cardiac arrest has not

been determined. In the 75 patients operated upon by the author, the shortest period of elective cardiac arrest was six minutes and the longest 58 minutes. The technique has been utilized in patients from six months to 59 years of age. Elective cardiac arrest has been used for the surgical correction of defects at the atrial and ventricular levels, relief of valvular and infundibular pulmonary stenosis, correction of mitral and tricuspid insufficiency, relief of aortic valvular stenosis, and an attempted correction of transposition of the great vessels. The size of the patient's

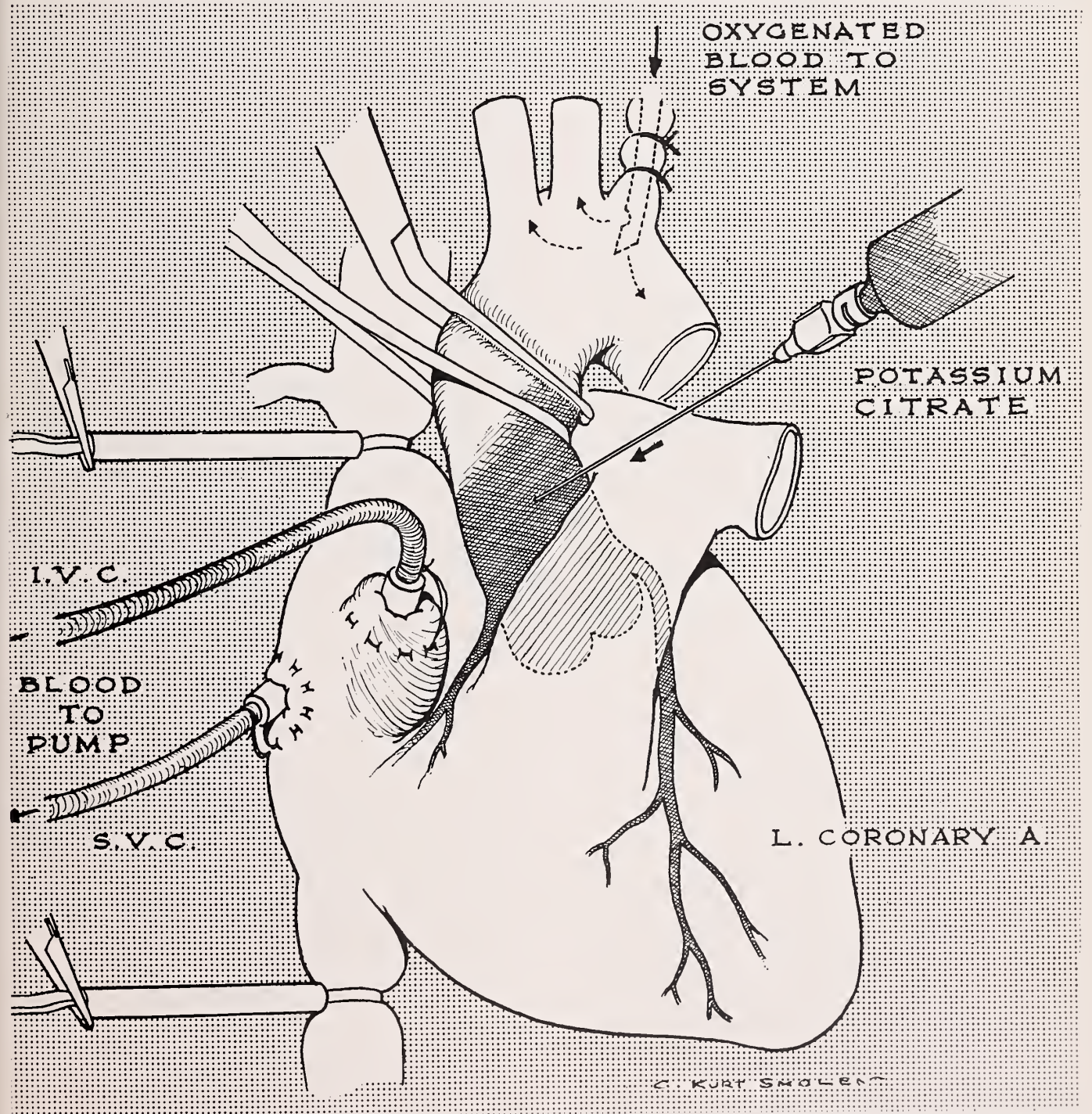


Figure 1: Technique of induced cardiac arrest by coronary perfusion with potassium citrate solution. The cavae are occluded by umbilical tapes and the heart is bypassed by means of a pump oxygenator (not shown). The aorta has been occluded midway between the aortic valve and the innominate artery. Potassium citrate solution is injected directly into the occluded aortic segment and will perfuse the coronary bed. Less than two cc. of a 25 per cent solution of potassium citrate mixed with 20 cc. of the patient's heparinized blood is necessary to induce arrest in a child's heart. The induced arrest is associated with myocardial paralysis. The heart appears to dilate as it becomes flaccid; actually the dilatation is apparent rather than real, because of complete relaxation of the muscle fibers.

WHAT IS AN OPHTHALMOLOGIST?

THE NATIONAL Medical Foundation for Eye Care was established last year to create a better public understanding of the professional and scientific standard for good eye care. The foundation has recently published a small pamphlet entitled "What is an Ophthalmologist?" The text, which is reproduced below, contains definitions of an ophthalmologist, an optician and an optometrist. Ophthalmologists have utilized the pamphlet extensively in informing their patients as to standards in eye care. All physicians may obtain copies of the pamphlet by addressing the Foundation at 250 W. 57th St., New York 19.

An *Ophthalmologist* is a physician—a doctor of medicine—who specializes in the care of the eye and all the related structures. He diagnoses and treats defects of focus, disorders of function, and all other diseases of the eye, prescribing whatever is required, including glasses. He is often concerned, as a consultant member of the medical team, with diseases of other systems of the body or general diseases which manifest themselves in the eyes—diabetes, toxemia of pregnancy, cancer, multiple sclerosis, tuberculosis and other infections, hypertension, muscular dystrophy and heart disease, among others. Ophthalmology is a branch of medicine and the ophthalmologist is an eye physician and usually also an eye surgeon.

An ophthalmologist has first completed the full course of medical studies, received the degree of

M.D., served an internship in general medicine and surgery in an approved hospital, and has then taken special training in ophthalmology. Like the family physician, the ophthalmologist and all other medical specialists are licensed to practice all branches of medicine and surgery. *Oculist* is a less commonly used name for ophthalmologist.

An *Optician* is a skilled technician, auxiliary to medicine, who supplies and fits glasses on the prescription of a physician. He is trained to make the necessary facial measurements; to formulate the specifications necessary, and to make the glasses or other appliances; and to adopt them to the patient, placing them properly in relation to the eyes. He supplies glasses or other appliances only on the doctor's authorization.

An *Optometrist* is a licensed person who has met certain legal and educational requirements and is permitted by the state to engage in the practice of optometry. He is not a physician or doctor of medicine. The word *optometry* comes from two Greek words—*opto*, meaning "eye," and *meter*, "measure." The optometrist measures the focus of the eye for glasses. He is not qualified or permitted to use drugs for these tests or for any other purpose. He is not qualified or permitted to diagnose or to treat ocular disease. He may supply glasses on his own prescription. In most states he is also permitted, like the optician, to fill the ophthalmologist's prescription for glasses. By law he is a limited practitioner.

CARDIAC ARREST / Effler

heart and the severity of the disease do not affect the safety of elective cardiac arrest, although they may influence the eventual outcome of the operation.

In the 75 patients operated upon during elective cardiac arrest, all but three had return of a satisfactory heart rhythm. Even those patients who were ultimately to die in the postoperative period demonstrated no untoward effect from the procedure of cardiac asystole. The three patients who died without return of a satisfactory rhythm were found to have mechanical occlusions of the coronary vessels from technical error, and it is believed that the Melrose technique in no way played a part in their fatal outcome.

Summary

Elective cardiac arrest, employing the Melrose technique with a potassium citrate blood mixture, and a pump oxygenator is a simple and safe procedure. It is indeed the most important adjunct to open-heart surgery since the development of the cardiac bypass techniques. This method has been employed in 75 operations for intracardiac abnormalities.

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POWER LAWNMOWER INJURIES IN GEORGIA, 1955 and 1956

Results of a survey by the authors are discussed.

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ROBERT M. ALDEN, M.D., and J. CLINTON TERRELL, MD., Atlanta, Ga.

LAST YEAR at the meeting of the Medical Association of Georgia a paper was presented on the subject of disabilities resulting from power lawnmower injuries. At that time the general nature of such injuries was discussed, and an estimate was made of the number occurring in Atlanta and throughout the state.

In the late fall of 1956, after the lawnmowing season was essentially over, a survey of Georgia physicians was made by means of a mail questionnaire in an attempt to more accurately measure the number and type of such injuries. This survey was conducted by the Accident Prevention Unit of the Georgia Department of Public Health in cooperation with interested private physicians.

The Statistical Unit of the State Health Department designed the survey, analyzed the data, and assisted in other technical matters. Briefly, the survey was conducted as follows. In an attempt to obtain significant results yet keep the cost at a minimum, it was decided that approximately one half of the privately practicing physicians who were likely to see such injuries should be questioned. Therefore the survey included only physicians in the following specialties: General practice, surgery, orthopedics, plastic surgery, thoracic surgery, neurosurgery, E.E.N.T., ophthalmology, pediatrics, internal medicine, and industrial medicine.

It was anticipated that few physicians would be able to supply detailed information on each accident so a general questionnaire was designed to obtain basic data for the years 1955 and 1956. Questionnaires were sent to 1,085 physicians with a self-addressed stamped envelope. Eight were returned because the physicians were not at the given address. Of the remaining 1,079 questionnaires, 468 or 43.4 per cent were returned to the Health Department. Five of the 468 physicians were either deceased or retired, leaving 463 practicing physicians who

answered. Power lawnmower accidents were reported by 26 (48.8 per cent) physicians while 237 reported no accidents. The practices of many of the physicians who reported no accidents were in specialties which would rarely, if ever, be called upon to treat such injuries.

It is to be emphasized that the survey included only privately practicing physicians. No attempt was made to collect information from the emergency rooms of large hospitals throughout the state like Grady Memorial, Emory University, or the University Hospital in Augusta, and no attempt was made to measure the number of minor injuries which were not treated by physicians.

Findings

During the two-year period covered by the study, 737 power lawn mower accidents, resulting in 794 injuries, were reported by the 463 physicians who returned questionnaires. As shown in Table 1, gasoline rotary mowers were involved in 82.5 per cent of the accidents, gasoline reel mowers in 7.7 per cent, electric rotary mowers in 5.4 per cent, with the type of mower not indicated in 4.3 per cent.

Total, 1955 & 1956		
	Number	Per-cent
Total	737	100.0
Gas rotary	608	82.5
Gas reel	57	7.7
Electric rotary	40	5.4
Type not indicated	32	4.3

Table 1: Accidents reported, number and percentage, by type of mower involved, Georgia, 1955-1956.

Table 2 reveals that 69.6 per cent (553) of the injuries were due to direct contact with the mower, while the remaining 30.4 per cent (241 injuries) were caused by objects being thrown by the mower blade.

The authors would like to express their appreciation to all of the physicians who cooperated in this study.

	Total, 1955 & 1956	
	Number	Per-cent
Total injuries	794	100.0
Injuries by direct contact		
with mower	553	69.6
Injuries by objects thrown		
by mower	241	30.4

Table 2: Injuries reported, number and percentage, by manner of injury, Georgia, 1955-1956.

Of the 553 injuries due to direct contact with the mower, 66.2 per cent were injuries to the toes or feet, 25.8 per cent were injuries to fingers or hands, and 8.0 per cent were injuries to other areas. (Table 3)

By classifying the 241 injuries due to objects being thrown by the mower blade according to the percentage of times that each portion of the body was involved, the following results were obtained: lower extremities, 69.3 per cent; trunk, 2.5 per cent; upper extremities, 5.0 per cent; head or neck (excluding eyes) 7.0 per cent; and eyes, 16.2 per cent. These data are shown in Table 3 below.

	Total, 1955 & 1956	
	Number	Per-cent
Injuries by direct contact with mower		
Total	553	100.0
Toes or feet	366	66.2
Fingers or hand	143	25.8
Other areas	44	8.0
Injured by objects thrown by mower		
Total	241	100.0
Lower extremities	167	69.3
Trunk	6	2.5
Upper extremities	12	5.0
Head and neck (excluding eyes)	17	7.0
Eyes	39	16.2

Table 3: Injuries reported, number and percentage, by manner of injury and portion of body involved, Georgia, 1955-1956.

As indicated in Table 4, complications developed in 9.3 per cent of the injuries while 14.1 per cent resulted in some type of permanent disability.

	Total, 1955 & 1956	
	Number	Per-cent
Total all injuries	794	100.0
Developed complications	74	9.3
Resulted in permanent disability	112	14.1

Table 4: Reported injuries that developed complications or permanent disability, number and percentage, Georgia, 1955-1956.

Among those physicians who reported injuries, 50.9 per cent expressed the opinion that in their practice they had noted an increase in the number of power lawn mower injuries treated during the past two to three years. Of the injuries reported in

this study, thirty more were reported for 1956 than for 1955.

Summary and Conclusion

The gasoline rotary type mower is involved in the majority of the accidents. It is believed that this high incidence of injuries is a result of the gasoline rotary mower being both more dangerous and more frequently used than the other types of mowers.

As might be expected most injuries are a result of direct contact with the mower, but a surprisingly high percentage (30.4 per cent) of the reported injuries were caused by objects which were thrown by the mower blade. The victims of such missiles were frequently not the operators of the machines.

Over 90 per cent of the injuries due to direct contact with the mower are injuries to toes, fingers, feet or hands. Many of the injuries, especially those involving the fingers and hands, are probably due to negligence on the part of the operator.

The high incidence of injuries to the lower extremities from objects thrown by the mower blade is probably an indication of the exposure of these portions of the body to this type of injury. On the other hand, the number of injuries to the eyes is extremely high when the small amount of body surface involved and low exposure to injury of this portion of the body are considered. This means that the ratio of persons struck by objects thrown by the mower blade to the number of such persons treated by physicians is probably very high.

The number of injuries producing permanent disabilities (14.1 per cent) was surprisingly high, and certainly attests to the violence of these machines.

In summary it may be said that this study indicates that the problem of power lawn mower injuries is one of considerable magnitude, and this is of great importance to the manufacturers and the sellers, as well as the users of power lawn mowers. If the number of injuries continues to increase in the next few years, and there is every indication that it will, the power mower, particularly the rotary type, conceivably may be designated as a public health menace. In view of the above situation, we would like to make the following recommendations:

1. That appropriate organizations (such as the National Safety Council, the Public Health Departments, etc.) and the lay press give as much educational publicity to this problem as possible. An accident prevention attitude should be emphasized.
2. That the various county medical societies develop programs on this subject, and encourage their members to speak before civic clubs, schools, churches, etc. Much can be done toward accident prevention in this manner, particularly when the local press helps.

THE MONTH IN WASHINGTON

Washington, D. C. Just how much money does the federal government spend on health programs and just how is it spent?

The answers are not easy to come by, but each year the Washington Office of the American Medical Association gathers together all of the bits and pieces of information needed to explain where and how the U.S. is involved in medicine, from cancer research to treating workmen's sniffles. Some of the material comes directly from appropriation bills, but where programs and projects are not identified there, the responsible government officials are consulted for the breakdown.

For all health and medical purposes, the U. S. during the current fiscal year is spending approximately two and one-half billion dollars. This, despite months of economy talk in the administration and in Congress earlier in the year, is about the same figure as last year.

The survey also unearthed some interesting side-lights that show, perhaps more graphically than the dollar marks, the extent to which federal medical activities are spreading among almost all agencies and departments.

At least 23 U. S. cabinet departments and independent agencies are engaged in some medical operations, and there are at least 79 separate health-medical activities worthy of listing and describing. Many of these in turn are responsible for scores and scores of individual operations.

This year the relatively new Department of Health, Education and Welfare tops the list of all departments in health-medical spending with \$849,394,800, bounding past Veterans Administration and Defense Department, which up to now have been at the head of the column. VA is spending \$849,374,000, within \$20,000 of HEW, but Defense Department this year drops back more than \$80 million, to \$702,000,000, largely because the decreasing size of the armed forces means fewer uniformed men and dependents to care for.

Next comes Atomic Energy Commission, but its medical spending of \$40 million—mostly for research—is far down the column from the Big Three.

International Cooperation Administration has \$37

million to help our friends overseas to raise their medical standards. The other 19 departments and agencies have substantially less, the last item being the \$12,145 allocated to the physician entrusted with keeping members of Congress as healthy as possible.

For the first time the AMA report compiles information on the programs in which the U.S. participates for payments because of disability. Among those receiving these payments are veterans, disabled beneficiaries under social security, disabled railroad workers, etc.

Because this money is not all federal and comes from several tax sources—OASI and railroad payroll deductions as well as general U.S. revenue—it is not added to other federal medical costs in the AMA study. For the current fiscal year the total of these "payments for disability" is about \$3.2 billion.

Notes:

Federal Trade Commission and Food and Drug Administration joined together to warn drug manufacturers against using "false and misleading claims" to promote drug products for use against Asian influenza. It was pointed out that vaccine is the only protection, and that a physician is needed if there are complications.

* * *

Meeting at the invitation of the Children's Bureau, a group of specialists in the health field discussed use of X-rays of the newborn and pregnant women and concluded that restraint must be exercised.

* * *

There has been remarkable progress in the last five years in the fight against tuberculosis, but there are still at least 250,000 active cases in the United States. This is the gist of a special nationwide survey by Public Health Service and the National Tuberculosis Association.

* * *

While visiting Russian women scientists were telling of a 25-cent drug to treat Asian influenza, it was learned that some members of the Russian Embassy staff in Washington had been vaccinated with American vaccine.

LAWNMOWER INJURIES / McClure

3. That all manufacturers of power lawnmowers produce only machines which meet the highest safety standards.

4. That retailers sell only safely constructed ma-

chines and instruct each user in the safe operation of the mower.

5. That users of power mowers develop an awareness of the potential danger of such machines and exercise all safety precautions.

3254 Peachtree Road

MEDICAL GRAND ROUNDS

at Grady Hospital

Two patients are interviewed, and pancreatic insufficiency is discussed.

THE FACULTY, Emory University School of Medicine

DR. CRAIG G. CANTRELL: For Grand Rounds today we are presenting two patients who have pancreatic insufficiency. The first of these will be presented by Dr. George Wallace and the second, by Dr. Embree Blackard. Drs. John Galambos and Julius Wenger will give us short discussions on the diagnosis of this disease, and Dr. Spalding Schroder will speak to us about the treatment. Time permitting, we will have an opportunity for questions and answers following this.

Case One

DR. WALLACE: M.D., a forty-two year old colored female was admitted to our hospital 19 days ago complaining of weight loss and greasy stools. In 1944 she developed severe abdominal pain following an alcoholic bout; she was hospitalized and a cholecystectomy was performed. At operation, the pancreas was noted to be unusually firm, and a biopsy was interpreted as subacute pancreatitis. Following this she did very well with no recurrent abdominal pain whatever. In 1952 she developed diabetes mellitus. This was well controlled until 1954, when she was admitted with diabetes acidosis. At this time abdominal films showed pancreatic calcification. In 1955 she developed steatorrhea. For this she was placed on pancreatin and a low fat diet with good response. Her last visit to the Out-Patient Department was in May of 1956, at which time she weighed 86 pounds.

Since her last visit, however, she reports that she has begun to lose weight and estimates that she had lost about 30 pounds. Eight weeks ago her ankles began to swell. Over a four-week period, the edema spontaneously subsided and did not recur. About six weeks ago she began to notice excessive amounts of fat in her stool again, and her stools were unusually bulky. This was despite the fact she was continuing to take her pancreatin, as well as attempting to maintain herself on a low fat diet. She was admitted to the hospital because of emaciation.

The positive physical findings included a very small but definitely emaciated colored female, who weighed 66 pounds. Bilaterally enlarged parotid glands were noted. Her tongue had a purplish color. There were cracks at the corners of her mouth, and her skin was very dry and scaly. Her liver was palpable at the costal margin, and she had a one-plus pedal edema.

In the hospital the patient was placed on pancreatin, a low fat diet, high carbohydrate supplying between 2,000 and 2,500 calories a day. She has received vitamins in therapeutic doses. The stigmata of vitamin deficiency have practically disappeared. On this regimen she has gained about 12 pounds, and her stools have decreased in number and bulk.

Laboratory examinations performed on the patient revealed essentially normal blood and urine studies and a non-reactive VDRL. Blood sugars have varied from 380 on admission to her most recent value of 150 milligrams per cent. Liver function studies included a thymol turbidity of $1\frac{1}{2}$ units; cephalin flocculation of three plus; total bilirubin of 0.6; BUN 15 mg of B.S.P. retention of 0 per cent at the end of forty-five minutes and an alkaline phosphatase of 8.8 Bodansky units. Her total protein has shown an increase from 5.5 gms. per cent on admission to a present 7.6 gms. per cent. Her albumin rose from 2.8 gms. per cent to 3.3 gms. per cent. Serum calcium was 9.8 milligrams per cent, and serum electrolytes were essentially within normal limits.

She had a duodenal drainage performed by Dr. Galambos, the results being interpreted as diagnostic of impaired pancreatic function. Both a starch and glucose tolerance test were performed, but both will have to be repeated. A carotene tolerance test was performed and will be discussed later by Dr. Wenger.

DR. CANTRELL: Thank you very much. Dr. Griffin will now show us her x-ray studies.

DR. GRIFFIN: The abdominal film shows diffuse calcification in the pancreas. (Figure 1) The small bowel series showed some small areas of mucosal thickening in the proximal jejunum, but this could

not be definitely ascribed to pancreatic disease. For the diagnosis of pancreatic disease, the flat plate and lateral film of the abdomen are the most useful x-ray examinations.

DR. CANTRELL: Would anyone care to ask the patient some questions?

DR. SCHRODER: What were you eating before you came to the hospital as your general diet?

THE PATIENT: Well, I ate most of my vegetables raw.

DR. SCHRODER: Were you eating any meat?

THE PATIENT: Yes, sir, I could have anything except pork in my diet.

DR. SCHRODER: Do you have any more pain in your abdomen?

THE PATIENT: No, sir, I don't have any pain whatsoever.

DR. SCHRODER: You haven't had any since 1948?

THE PATIENT: No, sir.

DR. CANTRELL: Any other questions?

QUESTION: She never weighed more than 100 pounds?

DR. WALLACE: The highest weight recorded in the chart is 90 pounds.

DR. CANTRELL: I think our best plan might be to go ahead and present our second patient and discuss them together. Dr. Blackard.

Case Two

DR. BLACKARD: W. B. is a fifty-year old colored male, who was admitted to Grady Hospital on the 18th of February in diabetic acidosis. In 1952 he was operated on for obstructive jaundice. At this time a large, hard, indurated mass was found in the area of the pancreas. This was thought to be malignant and was not biopsied. However, an overlying lymph node was biopsied, and a cholecystojejunostomy was done. At the time of this admission, the patient complained of two to four bulky bowel movements a day. Occasionally these were greasy and occasionally would float. He also complained of flatulence, gastric fullness, and intolerance to fatty foods. At that time he also had a history of alcoholism for the past ten years.

A year and a half prior to the present admission he was found to have diabetes. He was well controlled on 40 units of PZI insulin a day. About four months ago the insulin requirement increased up to 70 units of NPH and was not adequately controlled. One week prior to admission he ran out of insulin and was presented to the hospital in diabetic acidosis. On admission the positive findings were a semi-comatose, dehydrated colored male. He was complaining of abdominal pain. His w.b.c. on admission was 23,500. Hemoglobin was normal. Urinalysis showed four plus sugar, and three plus acetone. He had a 475 milligrams per cent blood sugar and the CO_2 was 4.8 m Equ/L on admission. He had x-ray evidence of right lower lobe pneumonitis. Serum amylase was 44 mg per cent,

serum proteins were 5.4 grams, (2.8 grams albumin). Prothrombin time was slightly elevated. Stools were yellow and frothy and showed undigested food particles and many fat globules. Starch tolerance and glucose tolerance tests at 30, 60, 120, and 180 minutes were 225, 330, 341, 396, and 402; and 340, 485, 570, 708, and 660 respectively.

The carotene studies will be reported later here. Duodenal drainage showed a thick, dark reddish-brown viscous fluid, which did not increase in volume after intraduodenal injection of hydrochloric acid. Electrocardiogram revealed poor T waves. The films of the abdomen showed calcification in the area of the pancreas.

DR. JOHN GRIFFIN: The flat plate of the abdomen shows much smaller calcifications in the area of the pancreas, and they are much less extensive than in the previous case.

Oftentimes in examining patients for pancreatic calcifications, it is of value to get a lateral film; and by giving a small amount of barium, one can see an anterior displacement of the stomach.

DR. SCHRODER: (examining patient) Are you feeling better now?

THE PATIENT: Yes, sir.

DR. SCHRODER: Have you had much pain in your abdomen over the last few years?

THE PATIENT: I have lately, a good deal of pain.

DR. SCHRODER: How often do you have pain?

THE PATIENT: Well, mostly it will be about once a month.

DR. SCHRODER: What does it feel like? Will you describe the type of pain?

THE PATIENT: Well, it feels something like a gas, something like that, low part of the stomach.

DR. SCHRODER: It hurts real bad, it is not just a nag?

THE PATIENT: Well, at times it will nag; but first it begins to hurt bad, and later on it just kind of wears off.

DR. SCHRODER: How long does this last from beginning to wearing off?

THE PATIENT: About four or five days, something like that.

DR. CANTRELL: Any questions?

DR. GALAMBOS: Do you have any soreness in your stomach after the pain is gone?

THE PATIENT: Just the least bit for a few days after the pain, not too long.

DR. WENGER: Does drinking whiskey make one of these attacks come on?

THE PATIENT: No, sir, I haven't had an attack from drinking whiskey lately.

QUESTION: Does drinking whiskey make the pain go away?

THE PATIENT: I haven't tried it.

DR. CANTRELL: Thank you very much. Dr.

MEDICAL GRAND ROUNDS / Emory

Galambos, I wonder if you could explain to us the results of your duodenal drainage and also give us your comments on the diagnoses of these two patients.

DR. GALAMBOS: First, I would like to say a few words about how this phase of pancreatic destruction can come about. These two patients have classical histories of chronic pancreatitis. In this late stage it is easy to diagnose it. The chronic pancreatitis syndrome is characterized by recurrent episodes of abdominal pain with prolonged remissions between attacks at first and may have more frequent recurrences later, until the whole gland is practically "burned out."

Early in the disease it is very important to differentiate pancreatic pain from biliary colic. Many of these people can develop jaundice and right upper quadrant pain during their acute episode. Interestingly enough, biliary tract disease is common among women and fat people. The incidence of chronic, relapsing pancreatitis is more common among males, and in some series the sex incidence is six to one.

I would like to caution you that sometimes this pain can simulate myocardial infarction. It can produce striking S-T and T wave changes in the electrocardiograms and give an elevated serum transaminase. Pain can localize in the anterior chest. It usually does not radiate, however, to the neck or to the arm.

Characteristically, when episodes of pain are prolonged and severe, it lasts for days rather than hours. It can be precipitated by injection of morphine. It may be associated with albuminuria and microscopic hematuria. Several patients, however, can reach the stage of marked pancreatic insufficiency without any previous history of pain; and then the differential diagnosis is a little bit more difficult. The first patient had a family history of diabetes. In the presence of a positive family history of diabetes, we are not on firm enough grounds to attribute diabetes to the destructive process of pancreatitis alone.

In the end stage, we find the classical triad of symptoms of diabetes, pancreatic calcification and steatorrhea. A fecal smear will show undigested, striated muscle fibres, suggesting also steatorrhea. These people lose not only fat in their stool, which is very obvious in steatorrhea, but also large amounts of nitrogen.

Chronic pancreatitis is not a disease entity. This is a syndrome and can be casually related to a variety of factors. (1) First there is the congenital one which is usually seen by the pediatrician. This is due to mucoviscidosis involving also the pancreas. (2) It can be due to trauma, which may occur during an operation. (3) Gall bladder disease or biliary

tract disease used to be "The Cause" of pancreatitis, ever since Halsted in 1901 found a gall-stone impacted in the ampulla of Vater in a patient with pancreatitis, and Claude Bernard described that pancreatitis can be produced in animals by injecting bile into the duct of Wirsung. However, looking at the evidence at hand, it is more likely that chronic pancreatitis causes biliary tract disease than vice versa. In the so-called common channel theory, the reflux of bile in the pancreatic duct is a prerequisite. However, only 15 per cent of the individuals have common channels. In repeating Claude Bernard's experiments it was found that injecting bile into the pancreatic duct is not enough, because it will not cause pancreatitis unless one injects an irritant with it, or the duct must be tied as well. The incidence of common duct stone in patients with pancreatitis is rather rare, and many people have common duct stones without pancreatitis. Operations designed to dilate the "fibrous" sphincter of Oddi do not rest on very firm ground, since the so-called fibrosis of the sphincter is a rather frequent finding in normal individuals.

(4) Another cause with which you are familiar is infection. Viral infection can cause pancreatitis. Mumps is associated with acute pancreatitis and also can develop into the relapsing, recurring variety. Infectious hepatitis can cause pancreatitis. Cases with fulminating hepatitis have been shown to be associated with destruction of pancreatic tissue. Those who recovered in some instances went on to the chronic, relapsing stage. Epidemics of viral pancreatitis among trout, due to coxackie strains, have been reported. The bacterial origin of pancreatitis is questionable. Parasites, however, can cause pancreatitis.

(5) Chemicals can cause chronic pancreatitis. For example, boric acid, methyl alcohol, or ethionine (which is a metabolic antagonist of methionine) can produce experimentally chronic pancreatitis.

(6) Metabolic derangements or metabolic factors can be the cause of pancreatitis. Frederick, in 1878 described the "alcoholic's pancreas"; and ever since we have been very much aware of the association of pancreatitis and alcoholism, though admittedly pancreatitis is rare among the large group of alcoholics. Alcohol, given intravenously, will not stimulate the pancreas. The mechanism by which alcohol might be a precipitating or causative factor is unknown unless one assumes that it is secondary to stimulating gastric acid secretion. Alcohol can cause duodenitis. The resulting edema of the ampulla can cause obstruction of the flow of biliary and pancreatic juices.

(7) There are several other less frequent causes of pancreatitis in this group. Hemochromatosis and hyperlipemia can be associated casually with recur-

rent attacks of pancreatitis. Nutritional factors again can be casually related to pancreatic function.

(8) Vascular disease may be a cause. In a variety of "causes" vascular insufficiency may be the final common path which will result in pancreatic injury and disease. There is a very curious correlation between arteriosclerotic vascular and heart disease, and pancreatitis. The Schwartzman phenomenon was shown in the laboratory to produce pancreatitis.

(9) Finally, a big group of patients will have no demonstrable cause of their disease.

DR. CANTRELL: Just briefly tell us about the results of the duodenal drainage.

DR. GALAMOS: The drainage was performed to demonstrate the ability of the pancreas to secrete water and bicarbonate. Secretion is a powerful stimulant of these, while the cholinergic drugs stimulate the enzyme secretion.

W. B.'s duodenal secretion had a strongly acid pH for forty-five minutes after the stimulation of pancreatic secretion. M. D. had had a cholecystostomy. Therefore, there was a constant flow of bile. In the presence of a normally functioning biliary system, secretion will inhibit bile flow; and one obtains mostly pancreatic juice. Both patients demonstrated marked inability to secrete bicarbonate. This is in-

dicative of insufficient pancreatic function. There were some other tests done.

DR. WENGER: I think it is very appropriate that the laboratory discussion comes after the clinical discussion. This syndrome can easily be recognized on clinical grounds with the aid of minimal laboratory studies. I think this is a relatively rare syndrome compared to acute pancreatitis, which is an extremely common disease and is seen very frequently.

The functional reserve of the pancreas is extremely great. It takes a great deal of damage to the pancreas to give one the syndrome that we are seeing here today. I believe one can make this diagnosis in these two patients with greatest ease because of the clinical entity of malnutrition, weight loss, a history of previous abdominal pain, diabetes mellitus, calcification in the gland, and clinical evidence of steatorrhea. It is not necessary to get fat balance studies on every patient. I think that the diagnosis in these two patients probably can be made by inspecting the stool specimens. This is a lost art, which I believe should be revived.

The major complications of chronic pancreatitis are three in number: (1) diabetes mellitus, (2) calcification, which is the residual of multiple episodes

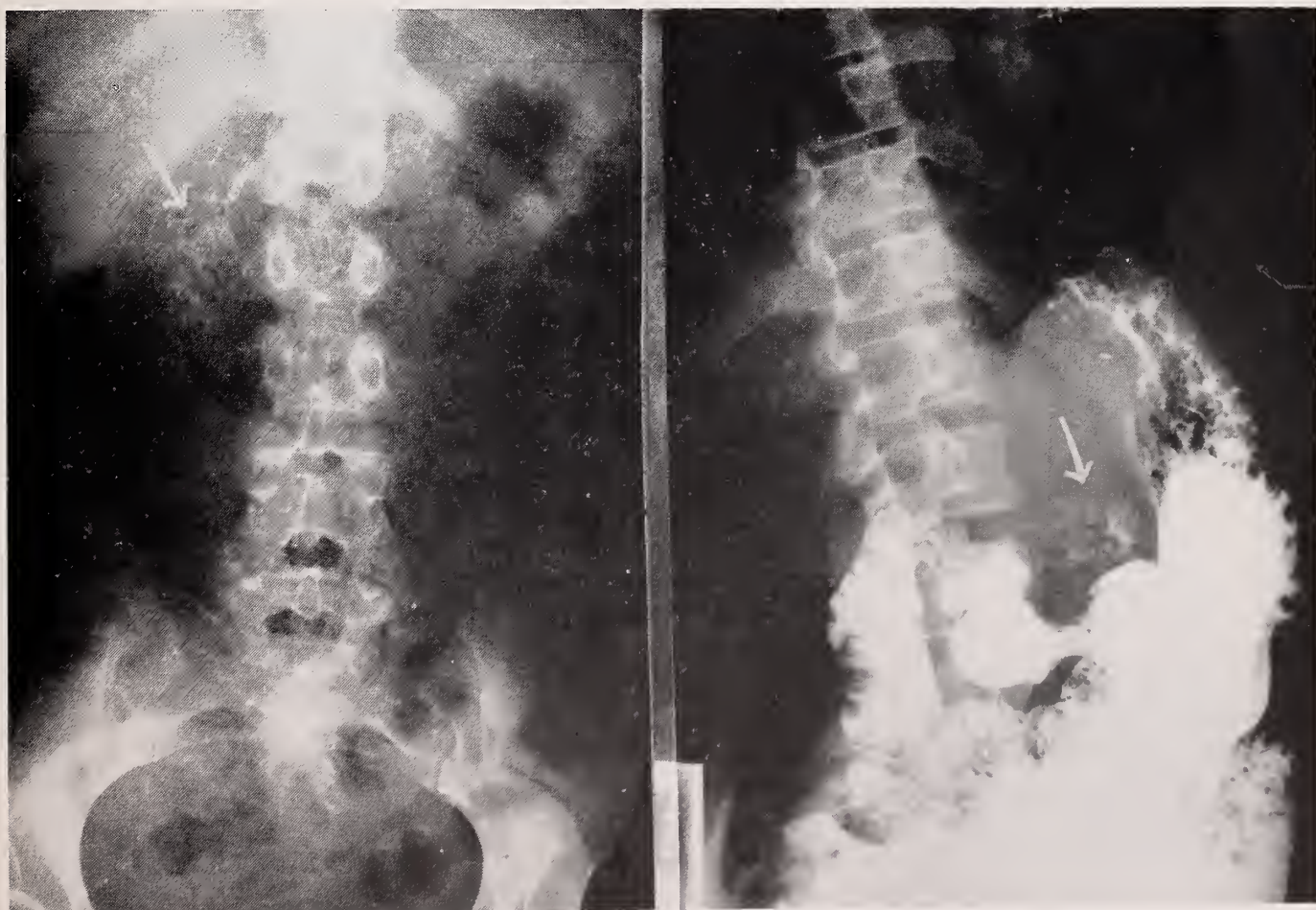


Figure 1A: A-P Roentgenogram of the abdomen. Numerous large areas of calcification are visible in the pancreas.

Figure 1B: Lateral roentgenogram of the abdomen. Areas of calcification are easily demonstrable in the body and tail of the pancreas. The boric acid filled duodenal bulb obscures the head of the pancreas in this picture. Note that the areas of calcification are more prominent on the lateral than on the A-P film.

MEDICAL GRAND ROUNDS / Emory

in which serum calcium combines with the fatty acids in the pancreatic gland to form calcium soaps.

Now, the third complication which is the most uncommon includes steatorrhea and creatorrhea. Steatorrhea means functional pancreatic insufficiency. The presence of the first two does not mean that the pancreas cannot handle the problems of digestion; but when steatorrhea occurs, this means definite pancreatic insufficiency which generally needs replacement therapy. Another uncommon complication is pseudocyst of the pancreas. It is primarily handled by the Surgical Service and generally responds well to internal drainage operations.

The laboratory methods to diagnose diabetes mellitus we need not comment on. Calcification of the gland is visible on the x-ray studies. Steatorrhea is more difficult because quantitative fecal fat studies are fairly complex. I have recently published a paper which describes a fairly simple technique which gives a fair estimate of steatorrhea. This method is the determination of blood carotene. Carotene is a pro-vitamin A which is absorbed parallel with dietary fat. M. D. had a serum carotene of 70 mg per cent, and W. B. had a serum carotene of 36 mg per cent. The normal range is 70 to 300, and 30 to 70 is moderate depletion, and 0 to 30 is severe depletion. We can therefore conclude that W. B. definitely has evidence of malabsorption of carotene; and, we presume, of fat, whereas M. D. seemed to be absorbing fat fairly well. I noted from looking at her chart that she has been receiving pancreatic extract in the hospital, so this may not be a true estimate of what her status was when she was first admitted.

Occasionally you see patients who have a low carotene level in the blood due to malnutrition. One can easily distinguish depletion of carotene due to a poor diet from depletion of carotene due to poor absorption by doing a modified tolerance test. In these cases we administered 50,000 units and repeated the test in forty-eight hours. In M. D. the blood carotene rose to 101, indicating that she can absorb carotene, whereas in W. B. there was no significant increase of blood carotene level. So, I think that I can say at the present time that W. B. has definite steatorrhea and malabsorption, whereas M. D. seems to be doing pretty well in her treatment.

The starch tolerance test is a relatively insensitive method. It is primarily useful in patients with rather marked pancreatic insufficiency. I believe that when you have two or three complications the secretin test will almost certainly be positive as it was in these two cases. The secretin test and the duodenal intubation method are the most sensitive methods of studying pancreatic function. There have been

published reports indicating that in the absence of all these complications one can demonstrate the earliest sign of damage to the pancreatic gland by the fall in the bicarbonate secretion. For the most practical purposes, we should withhold this test for the questionable and borderline cases where none of these complications are present.

DR. CANTRELL: Thank you very much, Dr. Wenger. Dr. Schroder, I wonder if you might speak to us for a few minutes on the treatment of chronic pancreatitis. Then we will have some questions.

DR. SCHRODER: The problem of pain is usually the biggest problem in the management of chronic, relapsing pancreatitis. The management of the steatorrhea is pretty well handled with the acceptable methods of pancreatic replacement therapy and an adequate nutritious diet. Diabetes secondary to chronic pancreatitis is generally fairly easy to control. I think this patient's diabetes is unusually severe. We have seen others who manifest acidosis, but diabetes, in general, does not offer such a serious problem. The real problem in the long run is the relief of pain, with which, incidentally, these two patients do not seem to be having much trouble.

In trying to outline a course of management, we, first of all, want to be very certain that the patient does not have stones in his gall bladder or common duct and that he does not have a stricture of his common duct or ampulla. The second problem is to be sure that the patient does not have cancer of the pancreas. This decision is generally one of clinical judgment; but at times it is necessary for an exploration to be carried out, at which time better assessment of the entire situation can be made. In general, however, medical treatment is to be recommended and can be adequately carried out in the majority of patients without having to resort to surgery.

If the patient is an alcoholic, he should be forbidden ever to use alcohol, since this is probably the most important offender in many of these people. Some direct toxic action on the pancreas of ethyl alcohol (as there is by methyl alcohol) is suggested by the apparent temporal relationship between alcohol ingestion and flare-up of pancreatitis. Bland diet, anti-acid regimen by the frequent use of alkali between meals, anticholinergics and sedatives are useful methods to inhibit pancreatic enzyme secretion as a result of inhibition of gastric secretion.

Many of these patients, because of the frequency of their pains, become addicted to narcotics, and that becomes the biggest problem. We have seen a couple of patients in whom it is extremely difficult to tell whether they are requiring narcotics for the relief of their pain, or whether they are having their pain in order to secure narcotics. Such things as

gastric suction and splanchnic blocks for acute exacerbations of chronic pancreatitis frequently prove to be of great benefit.

The principles of treatment are tabulated as follows:

1. Biliary tract surgery, if indicated by biliary tract disease.
2. Exploration if cancer suspected.
3. Medical treatment should be tried extensively before other surgery is recommended:
 - a. Bland diet and antacid regimen.
 - b. Specifically forbid alcohol.
 - c. Anticholinergics and sedatives.
 - d. Eliminate narcotics.
 - e. Six to eight pancreatin a day for steatorrhea.
 - f. Treat diabetes if present.
 - g. Gastric suction during exacerbations.

If medical treatment fails to keep the patient reasonably comfortable and well-nourished, an exploratory operation might be recommended. The surgeon should explore the pancreas trying to find frank evidence of pancreatitis, calculi, cyst, adenoma, abscess, or carcinoma as well as he can by palpation and visualization of the pancreas. Random biopsy is not very satisfactory, and the surgeons who do it find that they do not get sufficient benefit from biopsy to warrant its use generally, unless the biopsy is taken from grossly abnormal tissue.

If the pancreas does not offer some objective evidence of obstruction to its duct system, then I would think that it would be very worthwhile to explore the common duct, hoping that perhaps x-ray studies had overlooked some obstruction to the duct system down around the duct of Wirsung's entrance. If that proves normal, then explore the duodenum, looking up to the sphincter for possible stenosis. If there is no stenosis present, I do not think that sphincterotomy should be done. If everything looks

normal, then I would say the next procedure would probably be to go to the tail of the pancreas, resect a portion of it, and anastomose the duct to the jejunum.

DR. CANTRELL: Thank you very much, Dr. Schroder. From what you have heard of our two cases today, do you think either one of these would be candidates for surgery at this time?

DR. SCHRODER: I don't think it is indicated in either of these patients, because they are not having pain or sufficient malnutrition. I think they can be carried with replacement therapy.

DR. CANTRELL: I would like to ask Dr. Galambos one question. Did you do cytological studies on the drainage; and if so, was there any indication of malignancy in either one of these patients?

DR. GALAMBOS: I did not find clear-cut malignant cells in either one of these patients. There were some atypical cells in W. B.'s smears but not in M. D.'s case. The interesting thing was that, while gastric drainage in W. B. was clear, the duodenal drainage was a dark brown with necrotic shreds of material in it, which I have never seen before and I do not understand. It was faintly positive for guaiac. Had it been bloody, I would have expected a strongly positive guaiac test. On the smears I saw ghost cells but didn't see the bloody smear that I have seen in cases of carcinoma.

One test that is performed frequently for pancreatic function should be discouraged. This consists of putting a piece of stool on x-ray film and looking for signs of gelatin digestion as a diagnostic method for trypsin. Trypsin is not the only enzyme that will digest gelatin. Twenty-eight per cent of normal individuals will have bacteria that will produce a gelatinase, and there are other enzymes that will digest the gelatin.

DR. CANTRELL: This concludes our Grand Rounds. Thank you very much.

69 Butler St., S.E.

AMA-AHA COMMITTEE STUDIES MEDICOLEGAL PROBLEMS

A CONCERTED EDUCATIONAL PROGRAM on medical professional liability is being formulated by a joint committee of the American Medical Association and the American Hospital Association. Among other things, the liaison committee plans to study current medicolegal advisory set-ups in a number of states, the liability of charitable and governmental hospitals, and ways of promoting postgraduate education in the professional liability field. Progress reports will be submitted to the boards of trustees

of the two associations, and physicians and hospital personnel will be kept informed on all action taken through the organizations' official publications.

Representatives appointed from AMA include: Drs. Joseph F. Sadusk, Jr., Oakland, Calif., chairman; H. Close Hesseltine, Chicago, and William M. Nebeker, Salt Lake City. AHA representatives are: Ray E. Brown, Chicago; Dr. August H. Groeschel, New York, and James E. Ludlam, Los Angeles.



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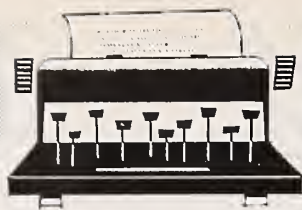
NEW DOSAGE. The recommended adult dose is 1 Gm. (2 tablets or 4 teaspoonfuls of syrup) the first day, followed by 0.5 Gm. (1 tablet or 2 teaspoonfuls of syrup) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive $\frac{1}{4}$ of the adult dosage. It is recommended that these dosages not be exceeded.

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1. Nichols, R. L. and Finland, M.: *J. Clin. Med.* 49:410, 1957.





editorials

MEDICARE PROGRESS REPORT

THE DEPENDENTS' MEDICAL CARE ACT, Public Law 569, has now been in operation in Georgia for approximately one year. To most doctors in the state, this is better known as the "Medicare Program." It would seem timely to discuss just what has happened in this program in Georgia during its first year of operation.

In the beginning, there was no way of anticipating the size of this program, the amount of money to be paid, or the way in which it could best operate. Representatives of your Medical Association went to Washington about twelve months ago and after some difficulty negotiated a contract with the Department of the Army which would permit the Medical Association of Georgia to act as the "Fiscal Agent" for the Medical Care Program in our state. It was the feeling of the officials of your Association that in this way the doctors of Georgia could be best informed about the various aspects of this program and be better qualified to determine just what was happening under Medicare. It is with some satisfaction that it can be reported now that the Medicare Program in Georgia has operated with great efficiency as far as cost is concerned. Many doctors in the state have not been completely satisfied with the rapidity of payments, but it must be understood that in its inception there were many delays in the operation of this program which prevented payments from being made as rapidly as the Executive Office would have liked to have made them.

During the original negotiations, it was anticipated that this Program would amount to the payment of some \$20,000 a month to various doctors in Georgia. It was felt that the Program might definitely be larger than this, but most certainly would be no smaller. During the past several months 2,000 claims per month have been processed in Georgia

alone, and the doctors in Georgia have received payments at the rate of \$135,000 per month. This is big business. It is more significant when one realizes that the majority of these payments go to the doctors of six cities. For the most part, these cities are in south Georgia and represent communities in which there are large military installations with inadequate local military medical facilities. With the Third Army Headquarters being located in Atlanta, there are more adequate military medical facilities and very few Medicare cases occur in our largest city. The Director of Medicare reported that he would estimate somewhere between two and three per cent of the cases are occurring in the Atlanta area. Another statistic of interest is that 39 per cent of all the claims are obstetrical and that 52 per cent of all monies paid out are for obstetrical care.

If the present wishes of some of our legislators are carried to completion, we understand that all citizens of this country who are receiving Social Security benefits and all employees under Civil Service as well as the dependents of these two large groups will be put under a medicare type program. When this will be done and how it will be done has not yet been made clear, but it has been definitely stated that it is the desire of many legislators to have such an extension of this government financed medical program. Should these groups be included under this or a similar program, it can readily be understood that the combination of these three large groups, military dependents, Social Security recipients, and Civil Service employees, will represent a significant percentage of our entire population. The medical bills for these three large groups will be sizable in Georgia. This is one of the major reasons why it is felt that the Medical Association of Georgia should continue to act as its own Fiscal Agent and keep "right on top of" this expanding medical program.

Representatives of the Medical Association of Georgia will negotiate a new contract with the Department of the Army shortly after the first of the year. The doctors of Georgia can be sure that their interests will be kept in mind and that the fairest, most workable program possible will be arranged with the Department of the Army.

VA FEE SCHEDULE

MEMBERS OF THE Medical Association of Georgia may become eligible to treat beneficiaries of the Veterans Administration on a maximum fee schedule basis and become participating physicians under the "VA Hometown Care Program" by writing the Association requesting eligibility.

EVALUATION OF FOREIGN MEDICAL GRADUATES

AFTER NEARLY THREE YEARS of planning, the Educational Council for Foreign Medical Graduates has placed an "open for business" sign on the door of its offices in suburban Evanston.

The council, which will carry out a detailed and comprehensive program for evaluating foreign medical school graduates, has offices in the Orrington Hotel in Evanston. The executive director is Dr. Dean F. Smiley, Chicago, former secretary of the Association of American Medical Colleges.

It was decided three years ago that some form of evaluation service should be established within an independent agency whose affairs would be directed by a board of trustees designated by four cooperating organizations, the American Medical Association, the Association of American Medical Colleges, the American Hospital Association, and the Federation of State Medical Boards of the United States. For the next two years, the council will be supported by the four sponsoring agencies, the Kellogg Foundation and the Rockefeller Foundation.

The council, incorporated in the State of Illinois, will be administered by a 10-member board of trustees—two representatives from each of the four sponsoring agencies and two persons representing the public at large, one named by the U.S. Department of Defense and the other by the U.S. Department of Health, Education and Welfare.

The president of the board is Dr. J. Murray Kinsman, dean of the University of Louisville School of Medicine.

Dr. Smiley said the council will distribute to foreign medical graduates around the world authentic

information regarding the opportunities and difficulties involved in coming to the United States on an exchange student visa in order to take training as an intern or resident in a U.S. hospital, or coming on an immigrant visa with the hope of becoming licensed to practice.

The council will make available to properly qualified foreign medical graduates, while still in their own country, all information on how to obtain certification. This involves a three-way screening process:

1. The council will certify that a student's educational credentials have been checked and found meeting minimal standards—18 years of formal education, including at least four years in a bona fide medical school, but excluding hospital training.

2. The council will certify that knowledge of English has been tested and found adequate for the needs of an internship in an American hospital.

3. The council will certify that the general knowledge of medicine, as evidenced by passing of the American Medical Qualification Examination, is adequate for assuming an internship in an American hospital.

The council also will provide hospitals, state licensing boards, and specialty boards, which the foreign medical graduate designates, with the results of the three-way screening. It also will accumulate and publish each year complete data regarding the numbers and placement of foreign medical graduates in this country.

VA FEE SCHEDULE / continued

In initiating this program, the Association contracted with the Veterans Administration a maximum fee schedule for any Association members eligible and desiring to administer such treatment. The contract with the VA was entered into June 29, 1948 and renewed annually.

The Association Veterans Affairs committee sought and received the approval of MAG Council to revise the schedule of maximum fees and negotiated with the Washington VA Office to effect the revision. The VA granted increases as recommended by MAG on all but 14 procedures. These 14 procedures will be further negotiated in January 1958. The approved increases were effective November

1957, and it is believed that the schedule of maximum fees is now more equitable.

Many Association members participate in this program from time to time. Eligibility to participate may be requested by any MAG member by merely writing the Headquarters Office, which in turn certifies to the VA that the physician is a MAG member in good standing, and then the VA lists the physician as an eligible participating physician for rendering medical care under the provisions of this program. The VA assigns patients to eligible participating physicians nearest the hometown of the patient.

Further information concerning eligibility, maximum fees for procedures, and provisions of this program may be obtained from the Headquarters Office.

It's Annual Session Time Again...

APPLICATION FOR HOTEL ACCOMMODATIONS
Medical Association of Georgia 1958 Annual Session
April 27, 28, 29 and 30, 1958, Macon

A Housing Bureau has been established for your convenience in making your hotel reservations in Macon for the 1958 ANNUAL SESSION of the Medical Association of Georgia. Comparable room rates are listed. Use the *Reservation Blank* below. Please specify your first, second and third choice hotel. All requests for reservations should give: (1) anticipated date and hour of arrival; (2) date and approximate hour of departure; and (3) names and addresses of all persons who will occupy the accommodations. ALL RESERVATIONS MUST BE CLEARED THROUGH THE HOUSING BUREAU. Since all requests for rooms will be handled in *chronological* order, you should mail your application as early as possible. All reservations will be confirmed.

Hotel	For Two Persons		
	Single	Double Bed	Twin Beds
DEMPSEY HOTEL	\$4.50-\$12.00	\$7.00-\$14.00	
GEORGIAN HOTEL	4.00- 4.50	6.00- 7.00	
LANIER HOTEL	4.00- 4.50	6.00- 10.00	
Motels			
AMBASSADOR MOTEL	\$4.50-\$6.00	\$6.50-\$8.00	\$7.50-\$9.00
MAGNOLIA COURT	4.00 and Up	\$5.00 and Up	
PINEBROOK INN	4.50	\$6.00 and Up	
Motor Hotel			
HOLIDAY INN OF MACON	6.50	\$9.50	

HOUSING BUREAU
MEDICAL ASSOCIATION OF GEORGIA
Macon Chamber of Commerce
Macon, Georgia

Please reserve the following accommodations for me for the 1958 Medical Association of Georgia Annual Session:

Hotel Preference	Kind of Accommodations Desired
1st Choice _____	<input type="checkbox"/> Double Room at \$_____ to \$_____
2nd Choice _____	<input type="checkbox"/> Double Room at \$_____ to \$_____
3rd Choice _____	<input type="checkbox"/> Twin bedroom at \$_____ to \$_____
	Other type _____
Arrival date _____	hour _____ A.M. _____ P.M.
Departure date _____	hour _____ A.M. _____ P.M.

THE NAME OF EACH HOTEL GUEST MUST BE LISTED. Include the names of all persons for whom you are requesting reservation and who will occupy the room(s):

Name of Occupant(s)	Address
_____	_____
_____	_____
_____	_____

Individual Requesting Reservations

Name _____

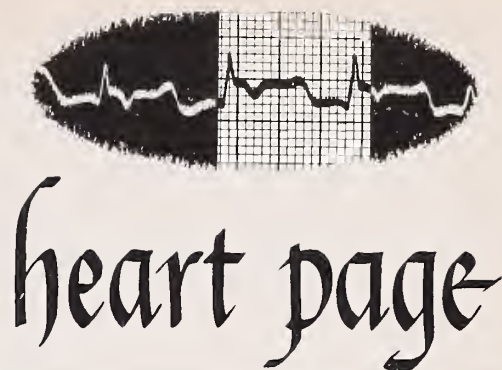
Address _____

City _____ Zone _____ State _____

If the hotels of your choice are unable to accept your reservation the Housing Bureau will make as good a reservation as possible elsewhere.

Selection of Patients for Mitral Commissurotomy

ROBERT G. ELLISON, M.D., Augusta, Ga.



THE SELECTION OF PATIENTS for mitral commissurotomy depends chiefly upon the clinical evaluation of the hemodynamic effects of mechanical obstruction of the mitral valve. Progressive narrowing of the mitral area leads to gradual increase in left atrial pressure and associated pulmonary venous engorgement. The resistance offered by the obstruction limits cardiac output. At rest, cardiac output may be adequate and the patient comfortable, but with exertion the left atrial pressure is further elevated, leading to additional venous engorgement and a sensation of dyspnea. Bouts of pulmonary edema, hemoptysis and right heart failure are additional evidences of serious organic obstruction of the mitral valve.

Any patient who presents such a clinical picture, that is, exertional dyspnea, bouts of pulmonary edema, hemoptysis, or evidences of right heart failure should be considered for exploration of the mitral valve. The ideal candidate is one with pure mitral stenosis.

The functional classification is helpful in evaluating patients for surgery. Surgery is not advised in the asymptomatic group (I). This applies, too, for most patients who have slight to moderate limitation in activity that is nonprogressive (Group II). The tolerance to such disability depends upon the individual. A patient in Group II may be able to perform sedentary occupations satisfactorily, but if his occupation necessitated greater physical effort his degree of incapacitation would be greater and, while still stationary, would justify the risk of operation. It is anticipated that an increasing number of patients in this group will be accepted for surgery in order to avoid irreparable damage to the pulmonary vascular bed or right heart. The results of commissurotomy in Group III are most satisfactory. These patients are deteriorating and often are desperate for help. They have serious degrees of pulmonary hypertension, right ventricular hypertrophy, and bouts of pulmonary edema.

Patients in Group IV are in an advanced stage of disease, usually in a state of chronic failure and are poor surgical risks. Although the risk of surgery in this group is greatest, since the outlook is hopeless otherwise, surgery is offered them and some can be palliated.

Other factors which have to be weighed carefully are age, rheumatic state, associate subacute bacterial endocarditis, arterial emboli, auricular fibrillation, and associated mitral insufficiency or aortic disease. In general, the patient in the third or fourth decade responds best to commissurotomy, but there is no age limit. Although the older patient is selected for surgery on the same basis as the younger one, it is recognized that morbidity and mortality will be higher and improvement will not be as impressive. Those under twenty should be carefully evaluated for evidences of active rheumatic disease.

As a rule, it is unwise to operate until rheumatic fever has been quiescent for several months. Sometimes, however, because of progressive deterioration, one is forced to go ahead in the face of smoldering activity. Also, it is desirable to defer surgery for four to six months after a bout of subacute bacterial endocarditis.

A history of arterial embolization may be considered an indication for exploration of the mitral valve. In these cases surgery may be technically more difficult because of thrombosis within the atrium and, too, the dangers of embolization during surgery are greater. Auricular fibrillation increases the surgical risk with more danger of embolization, but in no sense constitutes a contraindication.

The association of mitral insufficiency renders the decision for surgery more difficult, but if mitral stenosis is the predominant lesion, commissurotomy usually proves worthwhile. The association of aortic valvular disease further complicates the decision to explore any patient. Here again, if mitral stenosis is the predominant lesion, commissurotomy should be done, or if there is serious aortic disease a combined

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

valvular attack is justified. Pulmonary artery and pulmonary capillary wedge pressures obtained by right heart catheterization, and atrioventricular and ventriculoaortic pressure gradients obtained by left heart catheterization may be invaluable in evaluating the patient and in arriving at the proper surgical attack.

Patients are selected for mitral commissurotomy by a clinical evaluation of the effects of mitral valvular obstruction. In selected cases cardiac catheterization provides valuable information. Best results are obtained in patients with pure mitral stenosis who are seriously incapacitated and whose disability is progressive.

NEW MEMBERS of the MAG

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Robert C. Behrens	Cherokee Med. Bldg., Smyrna	Active	Cobb
Roy G. Duncan	1296 Medical Square, Marietta	Active	Cobb
Fort F. Felker, Jr.	606 Kenilworth Court, Dalton	Active	Whitfield
William Edward Holladay, Jr.	1202 Roswell St., Marietta	Active	Cobb
Martin L. Johnson	Bowdon, Ga.	Active	Carroll, Douglas, Haralson
Edward Leverett	Rutledge, Ga.	Active	Oconee Valley
Stephen C. May, Jr.	South Main St., Kennesaw, Ga.	Active	Cobb
Fujie Nakamura	Tri-County Hospital, Ft. Oglethorpe	Active	Walker-Dade-Catoosa
Julian Gary Palmer, Jr.	1422 Cherokee St., Marietta	Active	Cobb
John Sandberg	Cherokee Medical Bldg., Smyrna	Active	Cobb
Howard Marvin Sigal	Cherokee Medical Bldg., Smyrna	Active	Cobb
William Arthur Smith	3166 Maple Dr., N.E., Atlanta	Active	Fulton
Deverl T. Strickler, Jr.	47 Head Ave., Tallapoosa	Active	Carroll, Douglas, Haralson
Charles R. Underwood	404 Church Street, Marietta	Active	Cobb
William Talbert Williams	Cherokee Medical Bldg., Smyrna	Active	Cobb
William M. Wyatt	Macon Hospital, Macon	Active	Bibb
Anita Coyne Adams	Emory University Hospital, Emory University	DE-2	Fulton
Stuart G. Blackshear	107 N. Prior St., Gainesville	Active	Hall
Calvin LeRoy Edwards	Waugh Street, Dalton	Active	Whitfield
George I. Lebess	Batley State Hospital, Rome	Active	Floyd
Herschel Ulric Martin	Box 219, Hamilton Memorial Hospital, Dalton	Active	Whitfield
Nan Elizabeth Robinson	Harbin Clinic, Rome	Active	Floyd
Harrison L. Rogers, Jr.		Active	Fulton
Walter T. Sale	1293 Peachtree St., Atlanta	Active	Fulton
James Wesley Turpin	Chickamauga Med. Center, Chickamauga	Active	Walker-Catoosa-Dade
James Heiskell Venable	1415 Wynnton Rd., Columbus	Active	Muscogee
William N. Allen	710 Peachtree St., Atlanta	Active	Fulton
Sarah F. Cooley	35 Linden Avenue, Atlanta	DE-2	Fulton
C. C. Corley, Jr.	1530 Shoup Court, Decatur	Active	Fulton
Nicholas E. Davies	911 Medical Arts Bldg., Atlanta	Active	Fulton
Paul T. Erickson	50 - 7th Street, Atlanta	Service	Fulton
Lawrence L. Freeman	5252 Peachtree Road, Chamblee	Active	DeKalb
Harry B. Johnston, Jr.	4998 Peachtree Road, Atlanta	DE-2	Fulton
Houston W. Kitchin	356 W. Ponce de Leon Avenue, Decatur	Active	DeKalb
Tracy Levy	c/o Dr. M. S. Levy, 362 Dunn St., Smyrna	Service	Cobb
B. Lamar Murray	Waynesboro	Active	Wayne
Louis S. Riccardi	3166 Maple Dr., N.E., Atlanta	Active	Fulton
H. Hobson Rice	490 Peachtree Street, Atlanta	Active	Fulton
Maurice A. Strickland	127 Peachtree Street, Atlanta	Active	Fulton
Jack E. Tanner	35 Linden Avenue, Atlanta	DE-2	Fulton
Robert T. Willingham	187 N. Colonial Homes Circle, N.E., Atlanta	Active	Fulton
Nancy J. Wing	848 Peachtree Street, Atlanta	DE-2	Fulton
Earnest C. Atkins	VA Hospital, Brookhaven	DE-2	DeKalb
Joe D. Beasley	231 E. Ponce de Leon, Atlanta	Active	DeKalb
John Richard Castle	231 E. Ponce de Leon, Atlanta	Active	DeKalb
Robert H. Franch	Emory University	DE-2	Fulton

This is Your Society

W. B. SCHAEFER, Toccoa, Ga.



president's letter

IN MY VISITS over the state I find it appalling how few doctors really know how their medical association functions. I feel, therefore, that I should use this space to inform the members, especially the new members, of the intricate and democratic way that the organization is run.

The elected officers of the organization are the President, the Executive-Secretary, and the Vice-Presidents. The board of governors or Council of the organization is a ruling body during the interim meetings of the house of delegates. This body is made up of one elected officer of each congressional district and a chairman selected by the Council itself. It meets every three months and on call by the chairman or the president. The function of Council is to act as the financial body of the organization and to approve the disbursement of any and all funds.

From the Council and the officers, is elected an Executive Council which meets every month and represents the Council, performing the duties of that body between interim meetings. The Executive Council reports to Council on all of its activities and refers any controversial issue to the whole body of Council. The Executive Council is composed of the President, the President Elect, the Past President, the Chairman of Council, the Chairman of Finance, and the Executive Secretary.

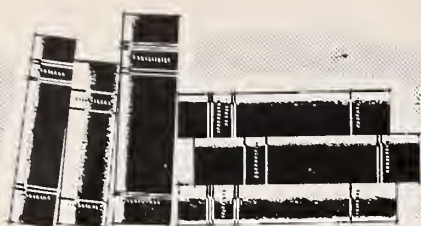
The actual ruling body of the association is the House of Delegates which meets only during the convention except by call of the president. (During my 25 years of membership, this has happened only

once.) The delegates are elected from each component society, so many delegates per members, and this forms the governing body. It is these members who should be elected with a great deal of thought. Men should be selected who have a great integrity, men who have the courage to stand up and openly speak their thoughts, and men with vision to vote, and to act for the benefit of all the doctors as a whole and not for a minority group.

I find that in the smaller societies most of the delegates are selected not by the above requirements but by the standard of "Who's going to the convention? Let's make him delegate." You can easily see the repercussion of this. The man who is selected may be tired. He needs a vacation and wants one that is tax deductible. He goes to the meeting to rest and recreate and does not give the House of Delegates his time nor his concentration. He is there to rest and he does. This attitude is something that should be remedied in our highest governing body. The component society, through its secretary and president, should be kept alert on the activities of the society and whenever possible, the delegates should be instructed by its component society as to its feelings. This is your society. It is no stronger than *your* interest.

RENEWAL OF LICENSES

ALL LICENSES TO PRACTICE medicine must be renewed by December 31, and failure to do so renders the license invalid. Renewal fee is \$3.00 before the 31st and \$10.00 if submitted after that date. Application blanks for renewal will be sent out to each physician by the Joint Secretary, Examining Boards, on December 1. Any doctor failing to receive such a blank should contact the office of C. L. Clifton, Joint Secretary, State Examining Boards, Atlanta, Georgia.



physician's bookshelf

BOOKS RECEIVED

Sugg, Redding, Jr., (Editor), **NUCLEAR ENERGY IN THE SOUTH**, Louisiana State University Press, Baton Rouge, La., November 1957, 138 pp., \$3.50.

Dahlin, David C., M.D., **BONE TUMORS**, Charles C. Thomas, Springfield, Illinois, October 1957, 219 pp., \$11.50.

Dickinson, C. J., **CLINICAL PATHOLOGY DATA** (Second Edition), Charles C. Thomas, Springfield, Illinois, October 1957, 81 pp., \$4.00.

Myers, J. Arthur, M.D., **TUBERCULOSIS: EVERY PHYSICIAN'S PROBLEM**, Charles C. Thomas, October 1957, 278 pp., \$7.50.

Troland, Charles E., and Frank J. Otenasek, **SELECTED WRITINGS OF WALTER E. DANDY**, Charles C. Thomas, Springfield, Illinois, October 1957, 789 pp., \$15.00.

Nice, Charles M., Jr., M.D., Alexander R. Margulis, and Leo G. Rigler, **ROENTGEN DIAGNOSIS OF ABDOMINAL TUMORS IN CHILDHOOD**, Charles C. Thomas, Springfield, Illinois, October 1957, 66 pp., \$4.00.

REVIEWS

Robertson, E. Graeme, M.D., **PNEUMOENCEPHALOGRAPHY**, Charles C. Thomas, Springfield, Illinois, 1957, 482 pp., \$14.50.

In a single volume Dr. Robertson presents a comprehensive discussion of pneumoencephalography as a neurological diagnostic technique. Based upon twenty years' clinical experience in Melbourne hospitals, the material is compactly and logically arranged for detailed reading or for reference use. The first chapters are devoted to the anatomy of the ventricular system and subarachnoid spaces. Clinical and experimental studies on the mechanisms of ventricular filling with gases is covered in some detail. Particular emphasis is laid on causes of failure of ventricular filling for technical or anatomical reasons and suggestions are given for correction. This is followed by description of the author's radiographic technique and a description of the normal pneumoencephalogram. The abnormal pneumoencephalogram is presented by regions with representative clinico-pathological correlations. Atrophic lesions, vascular disorders, head injuries and hydrocephalus are considered. Of particular interest to those concerned with neurological disorders of childhood is the section of pneumoencephalography in children, "a microcosm of encephalography." The final chapter on developmental abnormalities of the central nervous system is concluded with report on case reports of two sets of cephalically conjoined twins.

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

Radiographic illustrations are supplemented with tracings and diagrams which add greatly to their value, particularly for beginners.

The special nature of this volume does not recommend it to a universal medical audience. It should prove a welcome addition to the library of those concerned with neurology, neurosurgery, neuroradiology and related fields. It is recommended as a standard reference on pneumoencephalography to institutional libraries.

Donald S. Bickers

Reich, Walter J., M.D., and Nechtow, Mitchell J., M.D., **PRACTICAL GYNECOLOGY**, Second Edition, J. B. Lippincott Company, Philadelphia, 1957, 648 pp., \$12.50.

This second edition, just as the first edition, is written primarily for the general practitioner. The authors have added nine entirely new chapters. The reviewer feels that a book on practical gynecology should be concise, with emphasis given to the clinical recognition, and to the practical aspects of treatment. These conclusions should be based on a vast clinical experience. The contents of this book do not convey this impression.

The discussions on treatment are very brief and in many instances controversial. In a few cases the treatment outlined could prove harmful. A great deal of space, on the other hand, is devoted to the technique of some impractical laboratory tests.

Some favorable comment is due the authors for the chapters on "Psychosomatics of Gynecology" and "Low Fertility and Sterility." It is well illustrated with line drawings, clear photographs and contains 68 beautiful colored reproductions of some cervical lesions and vaginal smears. The book is easy to read, clearly and tastefully printed on a fine glossy paper.

John B. Cross, M.D.

Windle, William F. (Editor), **NEW RESEARCH TECHNIQUES OF NEUROANATOMY**, Charles C. Thomas, Springfield, Illinois, 78 pp., \$4.75.

This is a report of a symposium of neuroanatomists, published for investigators in the field of neurology. Technical developments of the last few years have opened up new horizons for research in this field and already much new information of both structure and function of the nervous system has been gained. Practical information regarding these new techniques are discussed. Subjects considered are: electron microscopy, silver impregnation of degenerating axones, selective silver impregnation of synaptic endings, tissue culture studies, local blood flow studies and quantitative histochemical studies. The material presented is most valuable for investigators in basic neurologic problems and of interest to clinicians who wish to keep informed of progress in these fields.

W. A. Smith

Lassek, A. M., M.D., **THE HUMAN BRAIN**, Charles C. Thomas, Springfield, Illinois, 1957, 212 pp., \$4.75.

The author is professor of anatomy at Boston University School of Medicine, Boston, Massachusetts. Dr. Lassek is more widely known as a neuroanatomist with contributions in his investigations of the pyramidal tract. References to these are included in his bibliography chosen from many spans of research in the progress of man's development.

In an effort to demonstrate the significance of environment upon the human brain, two theories as to hu-

man origin are offered: the magico-religious and the evolutionary.

Thence, the ensuing two hundred pages cover, numerically written, 6,957 years, presenting brief data accumulated from geological, scientific, anatomical, and physiological studies.

The major portion of the book is devoted to the evolution of the mind. This has been subdivided into three stages: savage, barbaric, and civilized. This evolution began with observation and comparison by the savage. Abstraction is suggested as the latest phenomena of man's brain development.

The Eskimo mode of life is utilized, as well as that of a group of primitive tribes living in Australia, to demonstrate this progress to man's development today. The various taboos and other superstitions recorded were found to be the more enjoyable moments for this reader.

The summary, clearing up to some extent the repetitious and loosely constructed material, restates two strong points: (1) man always behaves according to his need, and (2) the problem of man has become *man*. His answer suggests that this may more necessarily be found through cooperation, dignity, individual consid-

eration, and kindness rather than competition.

The book is "light" reading, and will raise some questions for consideration by each reader.

Fleming L. Jolley, M.D.

King, Edward L., OCCIPITO POSTERIOR POSITIONS, Charles C. Thomas, Springfield, Illinois, 957, 99 pp., \$3.75.

This book is a contribution that is valuable to the general practitioner as well as the specialist. That it is easy reading is a helpful and pleasant factor.

The material adequately and thoroughly covers the cause, diagnosis, management and treatment for occiput posterior position. The author presents all aspects of treating or correcting the occiput posterior position, even though he himself is not in full accord with all of them. Non-surgical as well as operative (forceps) methods are clearly described and well illustrated by drawings. It is surprising that the author never uses manual rotation of the head but employs forceps exclusively for this maneuver. However, one point that he makes clear, and which is truly a good conservative attitude, is allowing time for spontaneous anterior rotation to occur.

Robert H. Gillespie, M.D.

STUDY OF PREPAID MEDICAL CARE

Michigan doctors learned recently that most people in Michigan who subscribe to prepaid medical plans want more services, and are willing to pay for them.

The answers came through a public opinion survey conducted by the Michigan State Medical Society the past four months. The Study of Prepaid Medical Care Coverage in Michigan included results from an interview survey of 1,000 persons, a questionnaire mailed to more than 60,000 Michigan residents, a separate survey of doctor opinion and a compilation of facts from other surveys on this subject.

With 81 per cent of the population of Michigan covered by some form of health insurance, the vast majority are satisfied with the situation, the survey indicated.

Of those covered, 64.6 per cent have Blue Shield. Only 10 per cent expressed unfavorable opinion of the service; 64 per cent liked it, and 26 per cent were noncommittal.

The survey showed that Blue Shield subscribers believe they pay an average of \$5.95 a month for medical and surgical coverage. The actual average is \$2.83. The majority are willing to pay up to \$6.95 a month in order to obtain additional benefits.

The added benefit that most people would like to have is diagnostic service in hospitals. There is no overwhelming clamor for any single benefit, but many were mentioned. Many people said they would like to have Blue Shield pay for such things as x-rays, emergency house calls, vaccinations, surgery in doctors' offices, and medical consultations. Questioned regarding deductible medical-surgical cost payment, the result was almost an even division for and against. The majority of those in favor of such partial coverage voted for \$25 deductible per case rather than \$50 or \$100.

Dr. George Slagle, MSMS president, said in a discus-

sion of the survey before the House of Delegates, the report indicates that if a deductible plan were introduced, "there would be definite public acceptance."

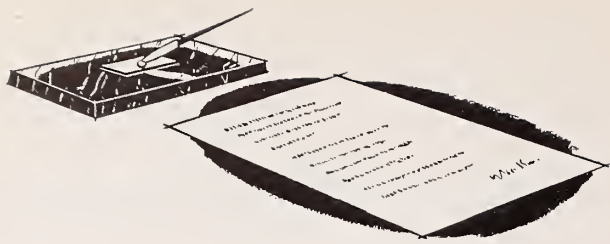
The doctors' main complaint against Blue Shield is "unfairness in the schedule of payments they received for their services." They felt that fee schedules have not kept pace with the rising cost of living, he said.

A conclusion in the 240-page, 10-pound report said: "There is evidence of sufficient dissatisfaction with various and sundry aspects of Blue Shield to warrant investigation of changes which might improve it."

On Wednesday, Sept. 25, the Michigan House of Delegates adopted the first major alteration in the Blue Shield program in nearly 17 years, reflecting the wishes of the public and doctors concerned with prepayment health insurance plans. These broad principles were outlined: (1) Broader benefits for subscribers. (2) A deductible and co-insurance type of contract, providing full payment for some services and partial payment for others. (3) An increased income-limit clause so that Blue Shield will cover the major costs for families up to \$7,500 of annual income. (4) Adoption of a series of unit values for various phases of medical care, including work by the family doctor, diagnosis, x-rays, surgery and all other treatment. (5) Endorsement of other insurers who want to set up the same type of coverage as Blue Shield, provided they live up to specified criteria.

Among the broader benefits mentioned were such services as surgery in a doctor's office, payment to physicians, consultants and surgical assistants in the hospital, all complications of obstetrical care, diagnostic services and wider x-ray coverage. Optional for future consideration would be payments for office or home calls by doctors, prescriptions, physiotherapy and artificial limbs.

From AMA Secretary's Letter



abstracts by georgia authors

Fowler, Noble O.; Walter L. Bloom; and Eugene B. Ferris, Grady Memorial Hospital, Atlanta, Georgia, "Systolic and Diastolic Pressure Relationships in the Isolated Rat Heart," *Circulation Research* 5:484-488 (September) 1957.

In the left ventricle of the excised beating rat heart, systolic-diastolic pressure relationships were studied under three circumstances: (1) spontaneous weakening of contractions; (2) ventricular alternans; (3) during increase of systolic pressure resulting from epinephrine and one nor-epinephrine. A significant relation between positive systolic and negative diastolic pressure was found under these circumstances. These observations were consistent with the concept that negative pressure change due to elastic diastolic recoil is inversely proportional to the ventricular volume following the preceding systole. These observations and others show that the isolated beating mammalian heart is capable of filling itself by diastolic suction in the absence of a hydrostatic pressure head. There is no indication, however, that diastole is in itself an active process.

Woodhall, J. P., 724 Hemlock Street, Macon, Georgia, "Traumatic Chylothorax," *Surgery* 43:780-786 (October) 1957.

Up to 1942 the treatment of traumatic chylothorax was accompanied by a 50 per cent mortality rate. In that year Lampson successfully performed a transthoracic ligation of the thoracic duct in a case of traumatic chylothorax. Since then 32 cases have been treated successfully by both surgical and conservative methods. The anatomy of the duct, diagnosis of injury and methods of treatment are reviewed. A case is presented of ductal injury in the root of the neck with the chyle emptying into the left thoracic cavity. It is emphasized that this injury presents a tremendous fluid and nutritional problem due to the loss of chyle, and that if spontaneous closure does not occur early surgical intervention is advisable and safe.

Florence, Thomas J., 403 Boulevard, N.E., Atlanta, Georgia, "Radical Cystectomy for Advanced Carcinoma of the Bladder," *J. Urology*, 78:410-413 (October) 1957.

In a 40-year-old colored male complete cystectomy and prostatectomy was done for advanced vesical carcinoma. The ureters were anastomosed directly to the posterior urethra over catheters. Complete regeneration of the "bladder" occurred and normal continence of urine resulted. This work was performed after reading of similar experiences in dogs. Reflux of urine up the ureters and possible later restriction of vesical capacity seem to be the only limiting factors. It is believed that this procedure has several advantages over placing the ureters into the bowel or skin.

Kaplan, William, D.V.M.; Lucille K. Georg, Ph.D.; Stanley L. Hendricks, D.V.M.; and Russell Leeper, D.V.M., Communicable Disease Center, Public Health Service, Atlanta, Georgia, "Isolation of *Microsporium Distortum* from Animals in the U. S.," *J. Invest. Dermat.* 28:449-453 (June) 1957.

The authors report the recovery of the dermatophyte *Microsporium distortum* from four pet monkeys and a dog that had been in contact with one of the infected simians. All five animals had clinical ringworm. The monkeys involved were of the new world type, recently imported into the United States from Central America. This is the first time this agent has been reported from the United States. These facts suggest the possibility that *M. distortum* was brought into this country by the imported monkeys. The public health implications of the animal infections are evidenced by the fact that six humans that had been in contact with three of the simians were reported to have developed ringworm.

M. distortum was first described in 1954 by Di Menna and Marples as a cause of human disease in New Zealand. These workers did not trace the human cases to an animal source.

Robert J. Hoagland, Colonel, MC Fort Benning, Georgia, "Diagnostische Kriterien der infektiösen Mononukleose," *Deutsche Medizinische Wochenschrift* (July 12, 1957).

This article was stimulated by the appearance of two papers¹ in which the diagnosis of mononucleosis was based solely on the detection of heterophil antibodies in blood and spinal fluid. The patients did not have enlarged lymph nodes or subjective manifestations of mononucleosis. Neither patient had a blood smear characteristic of mononucleosis; indeed, both had leukocytosis and marked polynucleosis.

In contrast to these diagnoses of mononucleosis based wholly on a laboratory test (heterophil antibodies), a review of several modern text books on hematology and internal medicine disclosed no change in the old belief that a positive heterophil antibody reaction is not necessary for the diagnosis of mononucleosis.

Hoagland believes that mononucleosis should not be diagnosed by the result of a heterophil antibody test alone; however, the heterophil antibody reaction properly performed is an indispensable criterion for diagnosis. When the clinical and hematologic features of mononucleosis are characteristic, the heterophil antibody test yields positive results.

Two clinical clues not widely known are mentioned: a midpalatal enanthem and sagging of the orbital and palpebral portion of the upper eyelids.

The author deprecates making the diagnosis of mononucleosis on any one, or two, of the three diagnostic criteria: (1) clinical, (2) hematologic, (3) serologic. None of these criteria are specific; all are characteristic. All are necessary for a sound diagnosis of mononucleosis.

Montague, F. E. and J. C. Thoroughman, Veteran's Administrative Hospital, Atlanta, Georgia, "True Diverticulum of the Prepyloric Area of the Stomach," *Am. J. Surg* 94:669-671 (October) 1957.

Of the 450 cases reported of true gastric diverticula containing all four layers of the stomach, approximately seventy have been found in the distal one-third of the stomach. These lesions constitute a distinct entity from those in the cardia. There are no characteristic symptoms of a diverticulum of the stomach. The diagnosis is usually made only by radiographic study. The complications are those of gastric and duodenal ulcer, consisting of perforation, obstruction, and hemorrhage. Aberrant pancreatic tissue in the diverticulum can be mistaken for cancer on frozen section.

A case history is presented in which these complications were seen and the difficulty of diagnosis exemplified. Because of the complications and difficulty of diagnosis it is believed that these lesions should be treated by surgical excision for diagnosis and treatment.

DID YOU KNOW?

The late Robert A. Taft classified the Social Security Act as our greatest single step toward socialism.

EXECUTIVE COMMITTEE

October 24, 1957

THE OCTOBER MEETING of the Executive Committee of the Council of the Medical Association of Georgia was called to order at 3:00 p.m., Thursday, October 24th at the Bon Air Hotel, Augusta by Chairman George R. Dillinger, Thomasville.

Present in addition to Dr. Dillinger were: W. Bruce Schaefer, Toccoa, President; Chris J. McLoughlin, Atlanta, Secretary; Hal M. Davison, Atlanta, Immediate Past President; Lee Howard, Sr., Savannah, President-Elect. Also present were Charles Hock, Augusta, President of Richmond County Medical Society, and Thomas W. Goodwin, Augusta, Speaker of the House of Delegates. Mr. Krueger and Mr. Kiser of the MAG Headquarters Office were also in attendance.

It was voted to dispense with the reading of the minutes of previous meetings.

Associate Executive Secretary

Mr. Krueger brought up the matter of changing the title of Mr. John Kiser from Assistant Executive Secretary to Associate Executive Secretary and it was so voted and directions given to list Mr. Kiser in the *Journal* and elsewhere as Associate Executive Secretary.

Hospital Advisory Committee Appointments

Mr. Krueger read a letter from Dr. R. C. Williams in regard to appointments to the Hospital Advisory Council. The Committee voted to make these appointments as requested by Dr. Williams with the actual names to be decided by the Chairman and President Schaefer.

Interprofessional Council

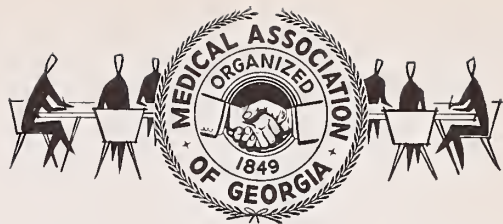
Dr. McLoughlin read a resolution from the Board of Directors meeting of Georgia Pharmaceutical Association as follows:

“The Board was briefed on the Medicare Program in the fact that pharmacy has been by-passed in setting up this program. It was pointed out that members are protesting the fact that doctors are dispensing drugs under the program. The Board directed that this matter be brought before the Interprofessional Council of Georgia, and further requested that the Medical Association of Georgia make a protest to the Chairman of the House and Senate Armed Forces Committee and the Department of Defense relative to the manner in which this program has been set up and the fact that pharmacy has been by-passed.”

After discussion it was voted to refer this resolution to Council with a recommendation for approval.

Dr. McLoughlin brought up the matter of unnecessary distribution of pharmaceutical samples by physicians per a protest of this practice as referred by the Interprofessional Council. After discussion it was voted to recommend to Council that a notice be published in the *Journal* setting forth the recommendations of the Interprofessional Council.

Dr. McLoughlin discussed various problems in regard to the Asian Flu vaccine and reported on a recommendation of the Interprofessional Council that the MAG write a letter of protest to pharmaceutical houses vio-



the association

lating the priority schedule. This recommendation was approved.

Disaster Committee

Mr. Krueger brought up a matter referred by Dr. Joseph A. Hertell, Area Medical Officer and Director of the Blood Program for the American National Red Cross in regard to the Association establishing a special Disaster Preparedness Committee. After a general discussion it was voted that this matter be referred to the Medical Civil Preparedness Committee.

Industrial Health Committee

The Executive Committee received information in regard to a meeting of the Industrial Health Committee on October 10th. The Committee recommended certain changes in the Workmen's Compensation Fee Schedule and reported that in regard to selection of physicians under the Workmen's Compensation Law, the Committee was aware that the problem exists and felt that every effort should be made to preserve the physician-patient relationship. This report was received for information.

Wildwood Sanitarium

Dr. McLoughlin read a letter from Dr. Joe Cruise in regard to the Wildwood Sanitarium and this was accepted for information.

Board of Health

Dr. McLoughlin mentioned a letter from the Board of Health replying to a request from the Medical Association of Georgia that the Secretary-Treasurer of the MAG be invited to attend meetings of the Board and that the officers of the MAG be furnished with copies of the agenda and minutes of the Board. After discussion, it was voted to thank the members for their letter and also to advise that a member of the State Board of Health is presently on the Rural Health Committee of the MAG as requested.

1958 Annual Session

Dr. McLoughlin reported on the plans for the MAG 1958 Annual Session and this was accepted as information and the Secretary-Treasurer was authorized to sign a contract for entertainment at the President's Banquet.

MAG Budget

Dr. McLoughlin also presented certain financial information in regard to the budget and this was accepted as information.

Better Business Bureau

The matter of membership in the Better Business Bureau was discussed and the Executive Secretary was instructed to study and investigate this matter for the next regular meeting.

Talmadge Hospital Problem

Dr. Dillinger reviewed the sequence of events in regard to the Talmadge Hospital problem.

Dr. Hock discussed problems on the Richmond County Medical Society level and stated that a special committee had been appointed to study the recent recommendations which would be taken up at the regular meeting of the Society on Tuesday, November 26th. He stated that it was his intention to write the Executive Committee of the MAG to attend this meeting.

There being no further business, the meeting was adjourned.

EXECUTIVE COMMITTEE

November 17, 1957

THE NOVEMBER MEETING of the Executive Committee of Council of the Medical Association of Georgia was called to order at 3:30 p.m., Sunday, November 17, 1957, Academy of Medicine, Atlanta, by President W. Bruce Schaefer, Toccoa.

Members of Executive Committee of Council present in addition to Dr. Schaefer were as follows: Lee Howard, Sr., Savannah, President-Elect; Hal M. Davison, Atlanta, Immediate Past President; Chris J. McLoughlin, Atlanta, Secretary-Treasurer; and J. G. McDaniel, Atlanta, Chairman of Finance. Messrs. Krueger and Kiser of the MAG Headquarters Office Staff also attended.

The minutes of the Council of the Medical Association of Georgia meeting September 14-15, 1957 were read and approved as were the minutes of the Executive Committee of Council meeting October 24, 1957.

School Health Insurance Problem

Secretary Chris J. McLoughlin presented correspondence from the Colquitt County Medical Society concerning the policies procedure of a health insurance company insuring school children and the relationship of this company to the profession in that area. This problem was referred to W. Bruce Schaefer who will correspond with the insurance company involved and the county society on this matter.

Appointment Vice Councilor Fourth District

It was voted that Virgil Williams serve as Vice-Councilor representing the Fourth District during the interval between Annual Sessions of the Association and this appointment will become effective immediately and the appointee shall serve until his successor has been elected and installed.

Ninth District Dues Resolution

Secretary Chris McLoughlin presented a resolution from the Ninth District Medical Society which stated the disapproval by that Society of the manner in which the increase in MAG dues at the 1957 Annual Session House of Delegates meeting was adopted. By general agreement, it was recommended that Secretary McLoughlin reply to this Ninth District resolution informing the Ninth District of the correct parliamentary procedure employed by the Reference Committee at the House of Delegates in the increasing of the annual MAG dues at the 1957 annual meeting and the correct subsequent action of the House of Delegates in unanimously adopting the Reference Committee recommendation.

Georgia Radiological Society Resolution

Secretary McLoughlin presented a letter from the Georgia Radiological Society regarding a resolution from that Society recommending the appointment of a special advisory committee of the Medical Association of Georgia on "Radiologic Safety," to serve as a liaison committee to the State of Georgia Department of Public Health. By general agreement, it was recommended that this resolution be referred to the Council, and further recommended that Council approve the request of the Georgia Radiological Society and appoint a committee of radiologists to function as requested in the resolution.

Walton County Medical Society Resolution

Mr. Krueger read a resolution of the Walton County Medical Society requesting assistance in the matter of Dr. Samuel DeFreese. After discussion, it was generally agreed that the Association Secretary write the Colquitt County Medical Society and inform them that from the data submitted in the resolution this does not appear to be either malpractice or give evidence of negligence in Dr. DeFreese's activity. It was further recommended that if the Society desires they can request the Medical Association of Georgia to refer this to its Professional Conduct Committee.

Hospital Advisory Committee Appointments

Mr. Kiser presented a request from R. C. Williams, Division of Hospital Services, State Department of Health, for appointments to the Hospital Advisory Committee, David Henry Poer was appointed to fill the expired term of Joe Reid, and P. W. Warga was appointed to fill the expired term of Julian Quattlebaum. These appointments were then approved.

Cultist Problems

Mr. Kiser reviewed the situation and activity concerning cultists. This data was received for information only and it required no action therein.

Talmadge Hospital

Secretary Chris J. McLoughlin reviewed the activity to date with reference to the Richmond County Medical Society—Talmadge Memorial Hospital problem. He then informed members of the Executive Committee that the Richmond County Medical Society had withdrawn their invitation to the Executive Committee to attend a meeting of the Richmond County Medical Society to be held November 26th. It was generally

agreed on the basis of this information that Executive Committee would then cancel their tentative plans to attend this November 26th Richmond County Medical Society meeting.

There being no further business, the meeting was adjourned.

BLOOD BANKS COMMITTEE

October 27, 1957

THE MEDICAL ASSOCIATION OF GEORGIA Special Committee on Blood Banks was called to order by its Chairman, Lester Forbes, Atlanta, at 2:10 p.m., October 27, 1957 in the Academy of Medicine, Atlanta.

Committee members present included: Lester Forbes, Atlanta, Chairman; Walter L. Sheppard, Augusta; Hamil Murray, Gainesville, and Dr. Josephs, American Red Cross representative.

Guests present included: Carl Fox, TB Association; John Venable, State Department of Health; Dr. Smith, Battey State Hospital; and, E. V. Hastings, Augusta.

Chairman Forbes reviewed the background of the MAG Blood Bank Committee and asked that the Committee consider general and specific problems of blood banks in the State of Georgia. He wished the Committee to formulate plans for Association activity in this area. He reminded the Committee members that the House of Delegates of the MAG had approved the minimum standards for blood banks at a previous session of the House of Delegates.

Chairman Forbes called on Carl Fox who discussed the difficulty in obtaining blood at Battey State Hospital. Mr. Fox also discussed tentative plans for a state conference on blood, proposed under the joint sponsorship of the Georgia Department of Public Health and the Medical Association of Georgia. He believed that such a conference would have a great educational value and that the Georgia Association of Pathologists, State Civil Defense Health Services, State Civil Defense Blood Procurement, Georgia Hospital Association, Georgia Association of Registered Medical Technologists, Talmadge Memorial Hospital, American Red Cross, Georgia Department of Public Health, including Battey State Hospital, Hospital Services and other interested divisions and the Georgia Association of Blood Banks, be invited to attend such a conference.

Chairman Forbes then called on Dr. Smith who explained the ways of obtaining blood for patients at Battey State Hospital. He outlined certain difficulties in getting blood for patients that are from certain areas and the problem of distance of donor from certain areas for patients at Battey was discussed. These same unorganized areas with no facilities seemingly create the problem.

Chairman Forbes called on Dr. Sheppard who discussed the situation in the past at the Augusta University Hospital blood pool and the bookkeeping and administrative problems inherent in this. He also discussed the present plan of operation at the Talmadge Memorial Hospital for the obtaining and using of blood.

Chairman Forbes then called on Dr. Venable who pointed out that certain Battey patients scheduled for

surgery have to wait until blood becomes available. Dr. Venable also emphasized that there are disaster and civil defense problems with blood banking and the need for a statewide system of blood banking. He assured committee members that the State and local health departments would cooperate and that equipment might be available from FCDA and state civil defense.

Chairman Forbes then called on Hamil Murray who said that there was no problem in the Hall County Hospital in this respect. He believed that the responsibility should be put on the patients in the community and that routinely, blood should be deposited prior to routine use. He further stated that in an emergency the hospital should be responsible and usually the blood will be replaced. He noted that there will always be some losses but that the ideal is to have a minimum loss in replacement.

Chairman Forbes then called on Dr. Josephs of the American Red Cross who stated that the Red Cross could enter into a cooperative effort with the American Association of Blood Banks and the Georgia Association of Blood Banks. He stated that demand sometimes exceeds supply and that the Red Cross can only provide for patients from communities having an American Red Cross organization. He has set up a priority system on collections from counties and is using a county credit system to aid in ascertaining these priorities. He stated that it was the policy of the Red Cross not to accept blood from other agencies.

Chairman Forbes then called on Dr. Hastings who gave the background and procedure of the Georgia Association of Blood Banks. He said that instead of minimum standards adopted by the MAG would be the basis for the operation of the Georgia Association of Blood Banks and then gave the purposes and objectives of a GABB. He stated that the GABB was an incorporated agency and was ready to function as soon as it could muster support.

It was voted that the Special Committee on Blood Banks recommend to the Council of the Medical Association of Georgia that the MAG sponsor, promote, and endorse the Georgia Association of Blood Banks. To effect this, it was recommended that Chairman Forbes and his Committee draw up a plan of education and promotion so that physicians, institutions and communities would cooperate with the Georgia Association of Blood Banks. It was further recommended that the Medical Association of Georgia and the Georgia State Department of Health jointly sponsor a meeting in February 1958 to inform, educate, exchange data and material, and promote the Georgia Association of Blood Banks to interested and participating agencies.

After further discussion, the meeting was adjourned.

ANNOUNCEMENTS

Six Days of Cardiology—Emory University School of Medicine, Jan. 13-18, 1958. Major problems of heart disease will be discussed by members of the Emory University faculty and visiting doctors. Tuition fee, \$100. For further information write to the Post-graduate Teaching Program, Emory University School of Medicine, 69 Butler St., Atlanta 3, Ga.

ANNOUNCEMENTS / Continued

Diabetes and Basic Metabolic Problems—Sixth Postgraduate Course—Academy of Medicine Building, Fulton County Medical Society, Atlanta, Ga., Jan. 22-24, 1958. Course offered by the American Diabetes Association. Subjects to be considered in detail include: Hormonal Influences in Diabetes Mellitus, Special Considerations in Diagnosis, Treatment, Problems Encountered in the Treatment of Diabetes, Stress and Strain. Fee is \$40 for members; \$75, for non-members. For further information write to J. Richard Connelly, Executive Director, American Diabetes Association, Inc., 1 East 45th Street, New York 17, New York.

Fifth International Congress of Internal Medicine, Philadelphia, Pa., April 23-26, 1958. The scientific program will include morning and afternoon sessions and will cover certain newer developments in the prevention, diagnosis, and treatment of disease. It will include an appraisal of clinical experience in various geographic areas. Among the subjects will be cardiovascular lesions that are now amenable to surgical therapy, the use of anticoagulants, physical medicine and rehabilitation, arthritis, oral remedies in the therapy of diabetes and the diagnostic and therapeutic application of radioactive agents. For further details write to Edward R. Loveland, 4200 Pine Street, Philadelphia 4, Pa.

DEATHS

H. L. ERWIN, Dalton, died October 16 at the age of 81. Dr. Erwin was a native Georgian and came to practice in Dalton in 1904, shortly after his graduation from the medical school of the University of Maryland at Baltimore.

Dr. Erwin was among the founders and original incorporators of Hamilton Memorial Hospital in Dalton. He was chairman of the Whitfield County Board of Health, charter member of the Dalton Civitan Club, and had been a member of the board of stewards of the Dalton First Methodist Church for more than 20 years.

In 1950, Dr. Erwin was honored by an unveiling of his portrait in the lobby of the Hamilton Memorial Hospital.

Dr. Erwin is survived by his wife, Mrs. Lucy Lynn Dickey Erwin; a sister, Mrs. Wright Mitchell; two brothers, Harry Erwin and Claud C. Erwin; and two stepdaughters, Mrs. Marjorie Taff Cooper of Valley Head Alabama, and Mrs. Kathleen Taff Wallace of Sheffield, Alabama.

L. PALMER HOLMES, Augusta radiologist, died unexpectedly in a local infirmary on October 28. Dr. Holmes was a graduate of Vanderbilt University and completed postgraduate training at Roosevelt Hospital in New York City and Johns Hopkins Hospital in Baltimore. He was a captain in the Army Medical Corps during World War I.

Dr. Holmes was head of the department of radiology at University Hospital for 36 years, professor of radiology at the Medical College of Georgia for 35 years,

a radiological staff member at St. Joseph's Hospital, a consultant to the Veterans Administration Hospital, and a diplomate of the Board of American Radiology.

He was a member of the Richmond County Medical Society, Georgia Radiological Society, Medical Association of Georgia, American Medical Association, American Society of Radiology, Radiological Society of North America, Augusta Country Club, and B.P.O.E.

Survivors include his wife; one daughter, Mrs. Richard Hammell of Summitt, N. J.; two brothers; two sisters; and four grandchildren.

JAY McLEAN, Savannah, known internationally as the discoverer of the anticoagulant substance heparin, died November 15, following a brief illness.

Dr. McLean, a native of San Francisco, had been living in Savannah since 1949 as director of the Savannah Tumor Clinic.

He had served as assistant radiologist, St. John's Hospital, Yonkers, N. Y., director of radiation therapy and assistant director of the tumor clinic of Yonkers Professional Hospital, director of the Tumor Clinic and director of radiation therapy at Yonkers General Hospital, and senior radiologist at Grant Hospital, Columbus, Ohio.

Dr. McLean is survived by his wife, Mrs. Georgia Sally Alpin McLean, and one son, Franklin Jay McLean.

L. P. PHARR, 85, retired Auburn physician, died in Jacksonville Beach, Florida, October 14.

Dr. Pharr was born in Buford in 1872 and settled in Auburn in 1900 after graduating from Atlanta Medical College, now Emory University School of Medicine.

Dr. Pharr was a member of the Tri-County Medical Association, Auburn Methodist Church, and Lodge No. 230 F&AM. In 1950 he was honored at "Dr. Pharr Day" by the town of Auburn on his retirement after 50 years of service as a physician. He was also awarded a 50-year service pin by the Medical Association of Georgia of which he was a member.

Survivors are his wife; one daughter, Mrs. Rex Lipham; two sons, Guerry Pharr, Winder, and J. B. Pharr, Jacksonville Beach, Florida; and one sister, Mrs. Marjorie Mauldin, Lawrenceville.

FRANK B. SCHLEY, 57, Columbus pediatrician, died October 21, following a heart attack.

Dr. Schley attended the University of Georgia and received his doctor of medicine degree from Emory University in 1924. A native Columbian, Dr. Schley began his practice there in 1926.

Being active in both civic and medical affairs, Dr. Schley was a past president of the Columbus Executives Club, past president of the Kiwanis Club, and a steward in St. Luke Methodist Church. He at one time held the position of president of the Third District Medical Society and of the Muscogee County Medical Society. He was twice a delegate of the Medical Association of Georgia, a member of the American Medical Association, a past president of the American Academy of Pediatrics, and a diplomate of the American Board of Pediatrics.

Survivors include his wife, Mrs. Susie Smith Schley, three sons, one daughter, six sisters, and two grandchildren.

DEATHS / Continued

SIDNEY LANIER WAITES, 71, Covington physician, died October 30, following a heart attack at his home. A native Alabamian, he received his medical degree at the University of Alabama, served his internship at Hillman Hospital, now Jefferson Hospital in Birmingham; and did postgraduate work at New York Medical Clinic.

Dr. Waites was a former Mayor of Covington, a Director of Newton Federal Savings and Loan Association, past president of the Civitan Club, a Mason, and a charter member of the Rotary Club.

He was a member of the Medical Association of Georgia, the American Medical Association, the Southern Medical Society, and the Newton County Medical Society.

Surviving are his wife, Mrs. Linnie Churchill Waites, four step children, one sister, and three brothers.

A. G. WORTHAM, 83, of the Centralhatchee Community in Heard County, died October 22, after an extended illness.

Dr. Wortham received his medical degree from the University of Georgia Medical School in 1904 and had practiced medicine in Centralhatchee for 53 years.

He was a deacon of the Centralhatchee Baptist Church, chairman of the Board of Trustees of the local school, and a Mason.

Last August Dr. Wortham was honored by his community on his 82nd birthday by a "Dr. A. G. Wortham Day."

Survivors include his wife, Mrs. A. G. Wortham; two sons, Hollis Wortham and Glenn Wortham; three daughters, Mrs. C. S. Heard, Mrs. Phillip Owen, and Mrs. J. Hugh Yeats; and one sister and a brother.

SOCIETIES

Members of the COBB COUNTY MEDICAL SOCIETY who attended the Southern Medical Association meeting in Miami, Florida recently included Robert P. Coggins, E. P. Englis, M. M. Hagood, E. A. Musarra, Robert Taylor Klingbeil, Remer Y. Clark, Jr., Warren B. Matthews and W. Claude Mitchell.

The GEORGIA MEDICAL SOCIETY, Savannah, has recently joined with the Savannah Bar Association in sponsoring a series of medico-legal forums in order to promote better relationships and understanding between the two professions.

At a recent meeting of the THIRD DISTRICT MEDICAL SOCIETY J. C. Patterson, Cuthbert, spoke on the subject of "Hysterectomies" and R. C. Pendergrass, Americus, gave a talk on "Tumors of the Colon." Wray Tomlinson, pathologist of the Columbus Medical Center conducted a clinico-pathological conference with Frank A. Wilson, of Leslie, leading the discussion afterwards.

The FIFTH DISTRICT MEDICAL SOCIETY met recently to hear Thomas E. Machella, M.D., chief of the gastro-intestinal clinic at the University of Pennsylvania, speak on "Functional Disturbances of the Gastro-

Intestinal Tract." During the meeting, W. B. Schaefer, Toccoa, President of the Medical Association of Georgia, presented a silver tray to David Henry Poer of Atlanta in appreciation of his service as past Secretary-Treasurer of the Association. At the meeting, the following officers were elected: Joseph H. Hilsman, Atlanta, President; W. P. Smith, Decatur, Vice-President; and Haywood Hill, Atlanta, Secretary-Treasurer.

At a business meeting of the MUSCOGEE COUNTY SOCIETY held recently, Henry Boyter, Columbus, was named President of the society. Other officers elected were George Epps as President-Elect, and A. C. Hobbs as Secretary-Treasurer. S. A. Roddenbery, Columbus, was elected as a delegate to the Medical Association and James W. Rhea and R. A. Chipman were named alternate delegates. At this same meeting, it was announced that the society planned to sponsor a special study course for medical secretaries and medical assistants. The society also endorsed a projected program of the Columbus Jaycees to urge all adults to obtain Salk vaccine injections.

Members of the WARE COUNTY MEDICAL SOCIETY met recently to elect officers for the coming year. Those elected were Robert H. Pompely, President, and Sage Harper, Douglas, Vice-President. At this same meeting a cancer film designed for laymen was shown to the group.



WALKER-CATOOSA-DADE MEMBERS MEET—E. M. Townsend, Sec., Walker-Catoosa-Dade Medical Society, left, discusses Society affairs with L. P. Williams, Ringgold, Vice President, right, and Jerome P. Sims, Ft. Oglethorpe, standing, center. Dr. Sims and Warren Terrell were the official hosts for the November meeting at the Tick Tock Grill, Chattahoochee. Dr. Williams presided at the meeting. Featured speaker was C. S. Buchanan and Mr. Glenn Fox with the Venereal Disease Control Division of the Georgia Department of Public Health.

PERSONALS

First District

JACK L. CANTOR, formerly of Long Island, New York, has recently opened offices in Statesboro for the practice of surgery and medicine. Dr. Cantor will be located at East Jones Avenue at South Zeterower Avenue. Dr. Cantor received his doctor of medicine degree at the University of Virginia and did post-graduate work at the University of Pennsylvania Graduate School of Medicine. He is a member of the American Medical Association, the Bulloch, Evans, and Candler Medical Societies and is a Fellow in Surgery of the New York Council of Surgeons. At present Dr. Cantor is on the attending staff of the Bulloch County Hospital.

CURTIS G. HAMES, Claxton, presented a paper before a meeting of the Southeastern Section of the Society for Experimental Biology and Medicine in Richmond, Virginia recently.

HUBERT U. KING, recently led a panel discussion on Mental Health at a meeting of the Register P.T.A.

LAMAR MURRAY, Waynesboro, has just completed a two weeks postgraduate course in "The Treatment of Fractures" in Chicago.

IRVING VICTOR, Savannah, has recently been named a Fellow of the American College of Surgeons.

Second District

T. GRAY FOUNTAIN, Albany, has recently become a member of the American College of Surgeons.

Third District

Participating in a panel at an annual P.T.A. workshop in Columbus were the following Columbus physicians: CHARLES R. SMITH, A. B. CONGER, JOHN



DISASTER PLAN OUTLINED—Officers and guests of the Whitfield County Medical Society posed for this picture following a talk by Joseph A. Hertell, Atlanta, regional medical director for the American Red Cross at the November meeting of the Society. Dr. Hertell, third from left, who has served as medical director in 10 major disasters, stressed the hospital and medical societies' responsibilities in regard to disaster planning. Pictured above, left to right, are Brooke F. Summerour, Dalton, President, Whitfield County Medical Society; Rep. Virgil Smith, Whitfield County Representative in the Georgia General Assembly; Dr. Hertell; Rep. Homer Winkle, Whitfield County Representative in the Georgia General Assembly; Lloyd Yeargin, Secretary, Whitfield County Medical Society. The members of the Society, meeting at the Hamilton Memorial Hospital, also heard talks by Representative Smith and Winkle.

K. DAVIDSON, III, BRUCE C. NEWSOM, and A. J. KRAVTIN.

The *Journal* regrets to announce the death of Mrs. Lucy Grace Davis, wife of E. B. DAVIS of Byromville.

It has recently been announced that Frank B. Schley, Jr., son of the late FRANK B. SCHLEY, SR., of Columbus, has assumed his father's medical practice at 303 11th Street, Columbus.

Fourth District

T. J. FLOYD, Griffin, has been appointed to head a committee of Griffin doctors elected to work with a similar committee of lawyers in an attempt to coordinate efforts of the two professions to better serve the local community. Serving with Dr. Floyd are A. P. JONES and VIRGIL B. WILLIAMS, both of Griffin.

G. R. FOSTER, JR., of McDonough announces the removal of his office to 55 Sims Street, office phone 3922.

JACK H. POWELL, JR., Newnan has recently become a fellow of the American College of Surgeons.

E. D. WELLS, LaGrange, recently addressed the LaGrange Optimist Club on the subject of fear of cancer.

Fifth District

At a recent meeting of the Georgia Diabetes Association in Augusta, several Georgia doctors participated in the program. Those speaking included GEORGE R. DILLINGER, Thomasville, President of the Association; WALTER L. BLOOM, Atlanta; JOHN K. DAVIDSON, Columbus; CHRIS J. MCLOUGHLIN, Atlanta; ARTHUR M. KNIGHT, Waycross; and ALEX T. MURPHEY, Augusta.

WILLIAM H. KISER, JR., Atlanta psychiatrist, was guest speaker at a meeting of the Briar Vista School P.T.A. Dr. Kiser spoke on the emotional growth of the child.

JACK C. NORRIS, Atlanta, was councillor at the Southern Medical Association meeting in Miami Beach in November. Dr. Norris represented Georgia at the meeting.

CHARLES E. TODD, JR., Atlanta, addressed members of the Georgia Ileostomy-Colostomy Association at a recent meeting in Atlanta on the subject of "You and Your Operation."

MAURICE A. STRICKLAND, East Point, was one of 20 Georgia physicians named a fellow of the American College of Surgeons at the 43rd annual convocation at Atlantic City, N. J.

CARL A. WHITAKER, Atlanta, was a recent guest speaker at a meeting of the Glenwood School P.T.A.

RALPH C. WILLIAMS, Atlanta, spoke at a meeting of the Atlanta Kiwanis Club on the topic of "Hospital and Medical Facilities."

Sixth District

Attending the Academy of Ophthalmology and Otolaryngology meeting in Chicago were ROBERT JAMES HOOPER, BRASWELL E. COLLINS, WILLIAM L. BARTON, J. O. MARTIN, and W. D. JARRAT, all of Macon.

Dr. and Mrs. JOSEPH E. LEVER, Sandersville, have recently returned from a Medical Cruise Seminar sponsored by Duke University Medical School. Dr. and Mrs. Lever travelled with a group of 30 doctors and their wives to Ireland, Scotland, Norway, Sweden, and Denmark, after which they left the group to begin a sightseeing tour to Austria, Germany, and back to Sweden.

JAMES W. PILCHER, Louisville, has been appointed head of the surgical hospital staff at Crawford W. Long. Dr. Pilcher will assume his new duties around the first of the year.

Seventh District

R. F. CORPE, Rome, was principle speaker at the Christmas Seal sale kick-off dinner sponsored by the Georgia Tuberculosis Association. Dr. Corpe spoke on "The Tuberculosis Problem." Also attending the dinner was JOHN H. GROSS, President of the Georgia Trudeau Society.

VIRGINIA HAMILTON MALEY, Cartersville, has been elected President of the Bartow County Unit of the American Cancer Society, Georgia Division. At the same meeting, THOMAS E. HAMILTON, Marietta, was named 2nd Vice-President of the Society.

Eighth District

E. ADAMS DANEMAN, Waycross, was the principal speaker at a Waycross P.T.A. meeting held recently.

HAROLD W. MUECKE, Waycross, was one of the Georgia pediatricians honored recently at a dinner citing past presidents of the Georgia Pediatric Society. Dr. Muecke, former president of the Society, is now president of the Ware County Medical Society.

Ninth District

C. B. SKELTON and RICHARD F. GRAVES, Winder, have recently moved their offices from the The Peoples Bank Building to the medical building on Midland Avenue.

WILLIAM L. CATON, former chairman of the Department of Obstetrics and Gynecology at Grady Hospital has opened offices for practice in Lawrenceville. Dr. Caton graduated from Washington University in St. Louis and did five years of graduate training in Boston. He is a former member of the Harvard Medical School faculty.

Tenth District

EDGAR R. PUND, Augusta, was chairman of the arrangement committee for the fifth annual meeting of the Inter-society Cytology Council held in Augusta.

CURTIS H. CARTER, Augusta, recently attended the Tri-State Tuberculosis Conference at Ponte Vedre, Florida.

ROBERT B. GREENBLATT, Augusta, has returned from a postgraduate course in obstetrics and gynecology of the American College of Surgeons. Dr. Greenblatt was also a featured speaker at the second

annual scientific session of the Jewish Hospital Center in St. Louis, Mo.

CHARLES W. HOCK, Augusta, was a guest speaker at the annual sales seminar of the Augusta Association of Life Underwriters. Dr. Hock's topic was "Peptic Ulcers, Their Influence on Insurability."

GEORGE F. McINNES of Augusta, has recently been elected to membership in the Society of Head and Neck Surgeons. Dr. McInnes has also announced the association of Harold S. Engler with him in the practice of general and neoplastic surgery. Dr. Engler was recently a full time instructor of surgery at the Medical College of Georgia and the Eugene Talmadge Memorial Hospital.

ROBERT R. MCKNIGHT, JR., Augusta, has recently become a fellow of the American College of Surgeons.

FORMER MAG SECRETARY RECEIVES AWARD



AWARD FOR DAVID HENRY POER—A highlight of the fall meeting of the Fifth District Medical Society was the presentation of a special award from the Medical Association of Georgia to David Henry Poer, Atlanta, left, by W. Bruce Schaefer, Toccoa, MAG President. Dr. Schaefer presented the silver tray on behalf of the Council and the House of Delegates to Dr. Poer for his outstanding services to the Association as Secretary-Treasurer from 1951 to 1957. Dr. Schaefer described how Dr. Poer had guided the Association through a difficult transition period and how now it was on a sound ethical, professional, and financial plane. The House of Delegates in May of 1957 adopted a special resolution directing that a suitable award or trophy be procured and presented to Dr. Poer.

SIXTH POSTGRADUATE COURSE

DIABETES and BASIC METABOLIC PROBLEMS

January 22, 23, 24, 1958

ATLANTA, GEORGIA

Preliminary Program

Wednesday morning, January 22

- 8:00 Registration
9:15 Introduction and Welcome
Christopher J. McLoughlin, Director

HORMONAL INFLUENCES IN DIABETES MELLITUS

- 9:25 Pituitary: *Basic Mechanisms*—Alfred E. Wilhelmi
9:45 *Clinical Applications*—E. Perry McCullagh
10:05 Adrenals: *Basic Mechanisms*—Jane A. Russell
10:25 *Clinical Applications*—Robert H. Williams
10:45 *Intermission*
10:55 Pancreas: *Basic Mechanism*—Arnold Lazarow
11:15 *Insulin*—Charles H. Best
11:55 *Glucagon*—Charles H. Best
11:55 Nonhormonal Factors Influencing Insulin Action—Robert H. Williams
12:15 Question and Answer Period

Wednesday afternoon, January 22

SPECIAL CONSIDERATIONS IN DIAGNOSIS

Chairman, Alexander Marble

- 2:00 Clinical History—Joseph T. Beardwood, Jr.
2:20 Laboratory Methods—Harvey C. Knowles, Jr.
2:40 Retinopathy—Albert A. Brust
3:00 *Intermission*
3:10 Neuropathy—Henry T. Ricketts
3:40 Nephropathy—Arthur J. Merrill
4:10 Errors in Diagnosis—John H. Warvel, Sr.
4:40 Question and Answer Period

Wednesday evening, January 22

Atlanta Biltmore Hotel

- 6:30 Social Hour (by subscription)—Crystal Lounge
7:30 Banquet—Georgian Ballroom

Thursday morning, January 23

TREATMENT

Chairman, William H. Olmsted

- 9:00 Diets: Selecting the Diet and Instructing the Patient—Alexander Marble
9:20 Use of Insulins in the Treatment of Diabetes—Franklin B. Peck, Sr.
9:50 Oral Hypoglycemic Compounds: Physiological Mechanisms of Action—Rachmiel Levine
10:20 *Intermission*
10:30 Oral Hypoglycemic Compounds: Clinical Usefulness—Garfield G. Duncan
11:00 Insulin Resistance—Francis D. W. Lukens
11:30 A Diabetic Clinic—Leon S. Smelo
12:00 Instruction of Students, Interns and Residents—Perry S. MacNeal

Thursday afternoon, January 23

PROBLEMS ENCOUNTERED IN THE TREATMENT OF DIABETES

Chairman, Francis D. W. Lukens

- 2:00 The Adolescent Diabetic—Harvey C. Knowles, Jr.
Discussion—E. Paul Sheridan
2:40 Atherosclerosis: A Survey—Henry T. Ricketts
3:00 *Intermission*
3:10 Vascular Complications in the Diabetic—W. Wallace Dyer
3:30 Hypertensive and Cardiac Complications—Arthur M. Knight, Jr.
3:50 The Overtreated Diabetic—Alexander Marble
4:15 *Panel Discussion*—Harvey C. Knowles, Jr., Henry T. Ricketts, W. Wallace Dyer, Arthur M. Knight, Jr., Alexander Marble

Thursday evening, January 23

- 6:30 Social Hour
8:00 Public Meeting—Diabetes Association of Atlanta

Friday morning, January 24

STRESS AND STRAIN

Chairman, Henry B. Mulholland

- 9:00 Management of the Surgical Diabetic—Frederick W. Williams
9:20 Infections—William F. Friedewald
9:40 Emotional Aspects—Paul L. Schroder
10:00 The Obese Diabetic—Francis D. W. Lukens
10:20 *Intermission*
Symposium: Socio-economic Problems of the Diabetic
10:30 Fitting the Diet to the Income—Louis K. Alpert
11:00 Marriage and Parenthood—Edwin W. Gates
11:30 Rehabilitation and Employment—Joseph T. Beardwood, Jr.
12:00 Life Insurance for Diabetics—Mr. J. E. K. Kennedy

Friday afternoon, January 24

STRESS AND STRAIN

Chairman, Franklin B. Peck, Sr.

- 2:00 Alterations in Protein, Carbohydrate and Fat Metabolism—T. S. Danowski
2:20 Acidosis: Alterations in Electrolytes and Hemodynamics—Thomas Findley
2:40 Rapid Quantitative Determination of Blood Ketones—Walter L. Bloom
3:00 *Intermission*
3:10 The Pregnant Diabetic—Henry B. Mulholland
3:30 Summarizing Stress and Strain—Arnold Lazarow
3:50 *Panel Discussion*—Faculty of Morning and Afternoon Sessions
4:30 Prophecies About Diabetes—Charles H. Best

Physicians Newly Licensed in Georgia

- Ernest Ackerly
1309 North Ave., N.E., Atlanta, Ga.
- Anita Coyne Adams
219 Little John Trail, N.E., Atlanta 9, Ga.
- Ernest Foss Adams
Georgia Warm Springs Foundation, Warm Springs, Ga.
- Jorge Antonio Alea
Battey State Hosp., Rome, Ga.
- James Hicks Alexander
41 Academy Ave., Dublin, Ga.
- Harvey Hamilton Allen
1019 Highland Ave., Winston Salem, N. C.
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Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

Published Monthly

Edited for the Association Under the
Direction of the Council of the Association

Established 1911

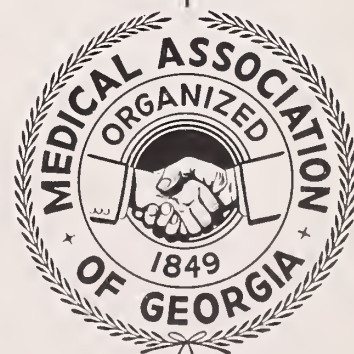
EDGAR WOODY, JR., M.D., EDITOR

Subscription Rates: \$5 a Year, \$1 a Single Copy

Volume 46 January-December, 1957

MEDICAL ASSOCIATION OF GEORGIA

875 West Peachtree, N.E., Atlanta



Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

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REPORT ON THE FORAND BILL

From AMA Assistant Secretary, Ernest B. Howard.

THIS LETTER IS DEVOTED in its entirety to the subject of social security hospital and medical benefits which have been proposed in the Forand Bill, HR9467, 85th Congress.

This legislation calls for the expansion of the Social Security Act into the medical and hospital care field. It has been referred to the House Ways and Means Committee, of which Mr. Forand is a member, and has strong backing of the AFL-CIO.

HR 9467 proposes that the federal government, through the Social Security System, pay the cost of hospital, nursing home, and surgical service for persons eligible for old-age and survivors insurance benefits.

This socialized medicine proposal for a large and growing segment of the American people is essentially the same as that of 1941-51, when the Wagner-Murray-Dingell bills called for "National Compulsory Health Insurance," except that it applies to a smaller segment at this time. The enactment of this legislation will permit the federal government to withdraw Social Security taxes on a compulsory basis from almost the entire working population and use those taxes to reimburse hospitals and physicians for services rendered to all persons eligible to receive old age and survivors benefits. It is estimated that at present there are approximately twelve to thirteen million persons in these categories.

The American Medical Association has repeatedly opposed compulsory health insurance and is unequivocally opposed to this new version.

What Is Being Done

The Board of Trustees, at the request of the Committee on Legislation, has appointed a special Task Force composed of Drs. George M. Fister, chairman; Frank C. Coleman, J. Duffy Hancock, George Gsell, and Robert Novy. Walter Polner, Ph.D., of the staff of the Bureau of Medical Economic Research has been assigned full time to the Task Force and is conducting an intensive research study of the health status of the population over the age of 65. He is collecting and collating data and opinions bearing on the following questions:

- (1) What is the extent of the problem?
- (2) What are the economic resources of the persons affected?
- (3) What are voluntary insurers doing and planning to meet existing needs?
- (4) To what extent does public assistance meet the need?
- (5) What is the relationship of the family to the aged persons in this group? specifically, what are the resources and obligations of children and grandchildren to the aged?
- (6) What is the incidence of hospitalization and illness by age groups?
- (7) What is the relative status of voluntary mea-

asures for the care of the over-65 age group today as compared to the situation five or ten years ago?

The answers to these and other questions will be incorporated in the Association's testimony before Congress and will be used in A.M.A.'s educational efforts.

The Committee on Legislation of the A.M.A. at the appropriate time will conduct its legislative campaign to educate key physicians and legislators regarding the potential adverse effects of these bills. Its program will be outlined and activated at a later date.

Position of AHA

The legislative position taken by the American Hospital Association on this question is of paramount importance. Endorsement by the AHA of OASI expansion to cover hospital and medical expenses would be a profoundly disturbing development. A.M.A. representatives, for that reason, have met with the special Committee on Aging of the American Hospital Association and in the near future will meet with the Council on Government Relations and the Board of Trustees of the AHA. The objective of these meetings is to acquaint the AHA with the position of the A.M.A. so as to make certain that the AHA will be thoroughly aware of the reasons for the A.M.A.'s position. The action of the American Hospital Association on this crucial issue will have a profound impact on hospital-physician relations.

Because of the fundamental importance of the position taken by hospitals, Dr. Allman, A.M.A. president, is sending a letter to all hospital chiefs-of-staff and administrators with the request that their boards of trustees be alerted to the dangers inherent in HR 9467.

Mr. Elwood N. Thompson, president of the First Trust Company of Lincoln, Neb., and a hospital trustee, was sufficiently disturbed after reviewing the Forand bill to have sent a personal letter to all hospital trustees in Nebraska and copies to the administrators of 3500 voluntary hospitals throughout the United States.

Outlook

The pressure for expansion of the Social Security System into the area of health and medical care benefits is formidable. Congressman Forand, Democrat, Rhode Island, has expressed his gratitude to the AFL-CIO for assistance in framing the bill. Many members of Congress will inevitably support such legislation because of pressure from their constituents, particularly those over 65, who will be favorably impressed by the immediate benefits to be gained. Social Security has been difficult to contain because of its intrinsic political appeal.

On the other hand, the strength of the opposition to this precipitate and revolutionary proposal is also great. Allied with the American Medical Association in its opposition are the American Farm Bureau Federation, the National Retailers Federation, the United States Chamber of Commerce, the life insurance

Georgia Congressmen, 85th Congress

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FOR BETTER GOVERNMENT . . .

Get the Facts

Study the Issues

Form Your Opinion

Inform Your Congressman

1. He should be addressed as Representative John Doe or Senator John Doe—not Mister.
2. Be brief, but not terse.
3. Be specific, positive—don't hedge.
4. Give him the local viewpoint—how the national issue would affect community health, your practice, your patients.
5. Letters should be dignified.
6. And reasonable—don't ask the impossible.
7. But request action—your Congressman was elected to *do* something.
8. Make it *your* letter—on *your* letterhead, in *your* style.
9. Request an answer—you've told him where *you* stand, now ask him where *he* stands.
10. Be appreciative—thank him for good things he does.

REPORT ON THE FORAND BILL continued

and health insurance industries, the National Association of Manufacturers and innumerable other organizations and individual citizens who are opposed to government intervention into medical and other private affairs. These organizations and individuals will again indicate their strong opposition to the nationalization of hospitals and medicine, just as they did in 1950 if the matter is brought to their attention. This process of alerting medicine's friends is now under way nationally. *State*

and country medical societies can immediately take similar action with state and local affiliated bodies of national organizations and other influential groups, whose policies are such that they would be expected to oppose socialized medicine.

It is anticipated that Secretary Folsom of the Department of Health, Education and Welfare will recommend that the Administration oppose the Forand Bill.

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